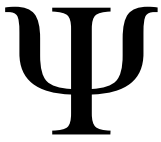
DET PSYKOLOGISKE FAKULTET



A Group-based Cognitive-Behavioral Intervention for Adolescent Depression: A Qualitative, Exploratory Study of Participants' Experiences

HOVEDOPPGAVE

Profesjonsstudiet i psykologi

Lene Bru

Høst 2010

Main supervisor

Roar Solholm

Second supervisor

Thormod Idsøe

Acknowledgements

First of all, I would like to thank Thormod Idsøe at the University of Stavanger for letting me take part in the evaluation of an early intervention for depressed adolescents, "Depresjonsmestring for ungdom". Secondly, I would like to sincerely thank all the informants who gave of their time to participate in the present study, and who have provided valuable information. I am also very grateful for good discussions, feedback and support from my two supervisors, Roar Solholm and Thormod Idsøe. Also thanks to Phd. student Margit Garvik for offering practical help throughout this process. At last, I would like to thank Elisabeth Andreassen for proofreading of the paper.

Abstract

Cognitive-behavioral therapy (CBT) has been documented to be effective in treating depression in adolescence, but there is great variability in the clinical outcome of CBT trials. This may in part be due to variations in content and emphasis on different CBT components. Moreover, little is known about adolescents' subjective experiences of CBT interventions, which also might be related to outcome. In this qualitative study, nine adolescents were interviewed about their experiences of the specific components in a CBT group intervention. As positive and negative consequences of the group format seldom are explicitly considered in CBT group interventions, it was also explored how the adolescents experienced the group aspect. The results showed that the adolescents experienced the cognitive component of the course as most useful, but somewhat difficult to use. Psycho-education, behavioral activation and the social relationships component were also experienced as beneficial. The experiences regarding the relaxation-training and the homework-assignments were mixed. Negative aspects of the intervention included the experience of guilt related to being depressed. The group aspect was generally considered as an advantage, and most of the adolescents expressed a preference for the group format over an individual approach.

Keywords: Cognitive-behavioral intervention, adolescent depression, client perspective, group processes.

Sammendrag

Kognitiv atferdsterapi (KAT) er dokumentert effektiv i behandlingen av depresjon hos ungdom, men det er stor variasjon i kliniske utfall i studier av KAT. Dette kan delvis skyldes variasjon i vektleggingen av og innhold i de ulike komponentene i KAT. Man vet i tillegg lite om hvordan ungdommene selv opplever KAT intervensjoner, og subjektiv opplevelse kan også være relatert til utfall. I denne kvalitative studien ble ni ungdommer intervjuet om deres opplevelse av de spesifikke komponentene i en KAT gruppeintervensjon. Da positive og negative konsekvenser av gruppeformatet sjelden blir studert ved KAT gruppeintervensjoner, ble det også undersøkt hvordan ungdommene opplevde gruppeaspektet. Resultatene viste at ungdommene opplevde den kognitive komponenten som mest nyttig, men noe vanskelig å bruke. Psykoedukasjon, atferdsaktivering og fokus på sosiale relasjoner ble også opplevd som nyttig, mens det var mer blandede opplevelser knyttet til avslapningsøvelser og hjemmelekser. Rapporterte negative faktorer ved intervensjonen var opplevd skyldfølelse i forbindelse med å være deprimert. Gruppeaspektet ble generelt ansett som en fordel, og de fleste ungdommene foretrakk gruppeformatet fremfor individuelle tilnærminger.

Stikkord: Kognitiv atferdsterapeutiske intervensjoner, depresjon, ungdommer, klient perspektiv, gruppeprosesser.

Content

A Group-based Cognitive Behavioral Intervention for Adolescent Depression: A Qualitative, Exploratory Study of Participants' Experiences

Major Depressive Disorder (MDD; see appendix A for the DSM-IV diagnostic criteria (APA, 1994)) is a relatively common problem in adolescence (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Kessler, Avenevoli, & Merikangas, 2001), especially amongst girls (Hankin & Abramson, 2001). A North-American study by Kessler and Walters (1998) estimated a point prevalence of MDD in adolescence of 6 %, while another study found a point prevalence of 3 % (Lewinsohn, Rohde, & Seeley, 1998). Lifetime prevalence rates have been reported between 4 % (Whitaker, Johnson, Shaffer, & Rapoport, 1990) and 24 % by the end of adolescence (Lewinsohn et al., 1998). Moreover, many adolescents have subclinical depressive symptoms (Kessler & Walters, 1998), which have been associated with the development of clinical depression in adulthood (Angst, Sellaro, & Merikangas, 2000).

Prevalence rates of MDD amongst adolescents in Norway are not well documented (Mykletun, Knudsen, & Mathiesen, 2009). However, there are some studies on the occurrence of emotional complaints. When combining the results of two Norwegian studies, about 13 % of adolescents between 13-15 years of age report significant emotional complaints, including symptoms of both anxiety and depression (Helland & Mathiesen, 2009). Mathiesen (2009) notes that the prevalence of MDD in adolescents is assumed to be somewhat lower in Norway compared to other Western countries.

Depression in adolescence is associated with a range of serious consequences (Essau & Chang, 2009). Adolescence represents a major developmental transition point, where adolescents make critical life choices related to education, work, as well as intimate relationships (Rao, Hammen, & Daley, 1999). Exposure to depression at this critical juncture in life could intervene with this process, and potentially have long-term

consequences. Indeed, research has shown that MDD in adolescence is associated with severe, pervasive psychosocial impairments that persist even after the individual no longer is experiencing clinical levels of the disorder (Paradis, Reinherz, Giaconia, & Fitzmaurice, 2006). Longitudinal studies, following depressed and non-depressed adolescents into adulthood, have found that depressed adolescents as adults had an increased risk of suicide, increased rate of both psychiatric and medical hospitalizations, lower educational achievement, extended time out of work due to psychopathology, and problems in interpersonal relationships (Rao et al., 1999; Weissman et al., 1999). Moreover, retrospective studies conducted amongst adults, suggest that 50 % of adolescents with depressive disorder will experience recurrence (Kessler et al., 2001). Because of the high prevalence, recurrence rates, and potential consequences of depression, the World Health Organization (WHO) expects depression to be the most costly health challenge in high-income countries by the year 2030. Depression is already the leading cause of disability for individuals between 15-44 years of age in developed countries (Mathers & Loncar, 2006).

A recent Norwegian study indicates that only 17 % of adolescents with significant psychiatric difficulties have been in contact with the mental health-service in the last 12 months (Helland & Mathiesen, 2009). There might be many reasons for this, one of them being the possible stigma associated with mental illnesses (Barney, Griffiths, Jorm, & Christensen, 2006). Another reason may be the organization and availability of the Norwegian mental health-service, which may make it difficult for the adolescent to get help. The low health-care utilization points out the need for better approaches for providing help to adolescents with mental health problems, for instance early interventions. Thus, the Norwegian Government has recommended a stronger emphasis on early interventions for psychiatric difficulties amongst both adolescents and adults (Halvorsen, 2009). Furthermore, to lower the threshold for seeking necessary help, the Norwegian

Psychological Association has early interventions as their primary area of interest from 2008-2010 (Hofgaard, 2008). They define early interventions as services that are (1) available to everyone; (2) provide help more or less immediately without having to be on a waiting list, or being referred by a physician; (3) free of charge, and (4) should have a high degree of involvement of the clients (Psykologforeningen, 2008).

In the last decades, there has been an increased interest in finding effective interventions for both prevention and treatment of adolescent depression (Weersing, Rozenman, & Gonzalez, 2009). Within the field of adolescent depression, cognitive-behavioral therapy (CBT) is by far the most studied psychological intervention, and has well documented efficacy (David-Ferdon & Kaslow, 2008). Although CBT has been documented to be effective in treating depression in adolescence, there is great variability in the clinical outcome of studies on CBT (Weersing et al., 2009; Weisz, McCarty, & Valeri, 2006). This may in part be due to that the different CBT interventions vary considerably in the content and emphasis on the different CBT components, such as cognitive restructuring and behavioral activation (Weersing et al., 2009). In spite of this, relatively little research has examined the core components of CBT. A related aspect is the fact that some research suggests that nonspecific factors often are more important for outcome than specific therapeutic techniques (Hougaard, 2004). Nonspecific factors refer to aspects of therapy that produce change, but are not specified in the theoretical delineation of the therapy, such as therapeutic alliance, expectations and group processes in group psychotherapy (Hornsey, Dwyer, & Oei, 2007; Oei & Shuttlewood, 1996). Nevertheless, there is also some research indicating that the inclusion of specific techniques is associated with a more positive outcome in CBT (see e.g., Kennard et al., 2009). It is likely that both specific techniques associated with the therapeutic orientation, as well as nonspecific factors are important for the outcome (Oei & Shuttlewood, 1996). Thus, there is a need for research addressing which

components, and what dosage of these components, might be the critical for an effective CBT intervention, as well as the influence on possible nonspecific factors on outcome (Weersing et al., 2009).

In recent years, there has been an increased focus on including the clients' perspective in clinical research, as their experiences might be related to clinical outcome (Hodgetts & Wright, 2007). The Norwegian Psychological Association also highlights the importance of taking into consideration the client's needs in the development of early interventions (Psykologforeningen, 2008). In the present study, a qualitative, exploratory approach is applied to explore how depressed adolescents (17-20 years) experience an early intervention in the form of a CBT group course. More specifically, the first aim is to explore how adolescents experience the specific components in CBT. This exploratory study may inform research that aims at investigating effects of different components of CBT.

The intervention in the present study is conducted in a group-format, as are many of the CBT interventions for depressed adolescents (e.g., "Coping with depression course", see e.g., Clarke, Debar, & Lewinsohn, 2003). It is likely that nonspecific factors such as group processes also contribute to the outcome of CBT groups, but this is seldom taken into consideration (Bieling, McCabe, & Antony, 2006; Hornsey et al., 2007). Therefore, the second aim of this study is to explore how adolescents experience the group aspect of a CBT group intervention.

As a theoretical background for the study, the following sections will give a presentation of CBT and its central components, followed by its empirical status. Thereafter, important group factors identified in traditional group psychotherapy will be introduced and applied to CBT groups. Lastly, the use of the client's perspective in clinical research will further be described.

Cognitive-Behavioral Therapy

CBT was developed in the 1960s, and Albert Ellis' Rational Emotive Therapy is often described as the first CBT (Engler, 2008). However, it is the cognitive therapy as developed by Aaron T. Beck that has become one of the major contemporary approaches to psychotherapy (White, 2000). As such, Beck's cognitive therapy, as well as his cognitive model of depression which the therapy is based on (Beck, Rush, Shaw, & Emery, 1979), will be introduced in the following sections.

Beck's cognitive model of depression. Cognitive therapy is built on the assumption that the individuals' emotions and behavior to a large extent are decided by the way the individual structures the world (Beck, 1970). Beck's cognitive model (1979) postulates three cognitive constructs to explain the psychological aspects of depression. The first is *the cognitive triad,* which consists of three cognitive patterns; negative view about the self, negative interpretation of experiences, and a negative outlook on the future. The cognitive model views the other symptoms of depression as a consequence of activated negative cognitive patterns. The motivational aspects of depression, such as lack of effort, can for instance be explained by pessimism and hopelessness.

The second component of the cognitive model is *schemas* (Beck et al., 1979). Conceptually, schemas are viewed as central to the model, and are described as relatively stabile internal structures formed by stimuli, ideas or experiences, and are used to organize new information (Hayden, Seeds, & Dozois, 2009). The schema determines how a phenomena is perceived, and when activated, decides how the person responds (Beck et al., 1979). During depression, the persons' perception of a given situation is distorted to fit the person's dysfunctional schema. As the depression gets more serious, thought processes are increasingly dominated by the negative assumptions (Beck et al., 1979).

The third component in the cognitive model of depression is *systematic errors* in thinking. This is used to explain why depressed people often maintain the belief in the validity of their negative thinking, despite contradicting evidence (Beck et al., 1979). Beck depicts different forms of erroneous information-processing, for example overgeneralization. According to Beck, one way of understanding the erroneous thinking that characterizes depression, is by separating "primitive" vs. "mature" ways of organizing reality. Depressed people have a tendency to structure their experiences in relatively primitive ways and make global assessments of events. These assessments are usually extreme, negative, categorical and absolute, and thus, the emotional reaction is often negative and extreme (Beck et al., 1979).

Beck's cognitive model postulates that early experiences are the foundation of a negative view of the self, the future and the world (Beck et al., 1979). These negative schemas are thought to be latent, and can be activated under specific circumstances. As such, Beck's model can be viewed as a diathesis-stress model, which implies that certain people have a cognitive vulnerability towards depression, which is activated under stressful circumstances (Hayden et al., 2009).

As for the empirical support of Beck's cognitive theory of depression, there is considerable evidence for the association between negative thinking and depression in adolescent populations (e.g., Garber, Weiss, & Shanley, 1993). For example, depression has consistently been associated with dysfunctional attitudes, negative automatic thoughts, pessimism, hopelessness, low perceived self-worth, negative explanatory styles and irrational beliefs (Hayden et al., 2009). However, research on the causal aspect of the theory, has yielded equivocal results (Lakdawalla, Hankin, & Mermelstein, 2007). In a review of longitudinal studies, Lakdawalla et al. (2007) assert that little is known about the applicability of the causal aspects of Beck's cognitive theory on depression in adolescents.

This is due to lack of research. Beck's cognitive model of depression has also yielded mixed results in the adult depression literature (Scher, Ingram, & Segal, 2005), but the results are generally supportive of the theory (Lakdawalla et al., 2007).

Research on another theory can shed light on the relationship between cognitive vulnerability and depression in adolescence. Hopelessness theory (see Abramson, Metalsky, & Alloy, 1989) is similar to Beck's cognitive model of depression in its assumption that some individuals exhibit a more depressogenic inferential style when confronted with a negative life event. There has been more research on hopelessness theory than on Beck's cognitive theory in the adolescent population (Lakdawalla et al., 2007). In general, there seems be a small to moderate interaction between vulnerability and stress in depression in adolescents, but more research is needed to establish this (Lakdawalla et al., 2007).

In addition to cognitive vulnerability, there are numerous other risk and vulnerability factors to consider in adolescent depression, including genetic and biological vulnerability, poor social relationships, lack of social support, as well as stressful life-events (see e.g., Hayden et al., 2009). However, an examination of the influences of these factors on depression, is beyond the scope of this paper.

Beck's cognitive therapy. Cognitive therapy can be defined as "an active, directive, time-limited and structured approach used to treat a variety of psychiatric disorders" (Beck et al., 1979, p. 3). At the core of cognitive therapy is identifying and challenging the negative distortions in thinking, that characterizes different mental disorders, such as depression. Beck developed several cognitive techniques for this purpose, for instance the Socratic dialogue. By critically examining the assumptions of one's thinking, one can learn to replace negative thinking by more realistic thinking, and thereby reducing depressive symptoms. The behavior therapy movement has also contributed to the development of

cognitive therapy, as seen through the inclusion of different behavioral techniques. Because of this, the approach is often called cognitive-behavioral therapy (Beck et al., 1979).

The therapy starts with psycho-education, which includes an explanation of the rationale of CBT. Beck et al. (1979) describe the therapy as including the following parts: (1) Self-monitoring of negative, automatic thoughts; (2) Recognizing the association between thoughts, affect and behavior; (3) Exploring the evidence around the negative automatic thought; (4) Replacing it with more realistic interpretations of these negative cognitions; (5) Learning to identify and change dysfunctional assumptions, which are predisposing to distorting experiences.

CBT was originally developed as a psychological intervention for adults (Beck et al., 1979), but is today widely used as a psychological intervention for children and adolescents as well (Weisz et al., 2006). In the following section, the empirical evidence of CBT in treating adolescent depression will be described.

Empirical Evidence of CBT in the Treatment of Adolescent Depression

In the last decades, there has been a quite a lot of research on psychological treatments of adolescent depression, and this research has mainly been conducted on CBT (Weisz et al., 2006). In general, adolescent versions of CBT are downward adaptations of adult treatments (Weisz & Hawley, 2002), and have therefore been criticized for not taking developmental issues in adolescence into account (Holmbeck, Greenley, & Franks, 2003). However, a literature review by David-Ferdon and Kaslow (2008) showed that CBT for depressed adolescents meet the criteria for "well established" treatments, based on the Task Force on the Promotion and Dissemination of Psychological Procedures guidelines (Chambless & Hollon, 1998).

Traditionally, CBT has been described and practiced in an individual format (Bieling et al., 2006). However, many of the CBT interventions for adolescents are conducted in

groups due to different reasons, such as cost-effectiveness (Tucker & Oei, 2007), and potentially reduced stigma compared to individual therapy (Clarke et al., 2003). A meta-analysis by Lockwood, Page and Conroy (2004) reported that group and individual CBT were equally effective and could be used to treat moderately depressed adolescents. Moreover, a review by Tucker and Oei (2007) suggests that the group format seems to be more cost-efficient when treating depression in adolescents. A well-documented example of CBT in groups for adolescents is the Coping With Depression Course (CWD-A), originally developed by Lewinsohn and his associates in the late 1970's (Cuijpers, Muñoz, Clarke, & Lewinsohn, 2009). The intervention in the present study has many similarities to this course.

Despite the apparent efficacy of CBT approaches towards the treatment of adolescent depression, several researchers, such as Weersing, Rosenman and Gonzalez (2009) and McCarty & Weisz (2007), point out the great variability in the clinical outcomes in CBT trials. Weisz et al. (2006) conducted a meta-analytic review of the effects of psychotherapy for depressed adolescents, and the results suggest a small to moderate effect (mean effect-size 0.34) in treating adolescent depression. The results of this meta-analysis contrast with three previous meta-analyses (Lewinsohn & Clarke, 1999; Michael & Crowley, 2002; Reinecke, Ryan, & DuBois, 1998), where they found large effects of psychotherapy on adolescent depression. However, several individual studies in the meta-analysis by Weisz et al. (2006) illustrated the potential for efficacious treatment, and three of the five especially effective treatments (effect-sizes over 1) were CBT. Nevertheless, the overall effect-size implicates a great variability in the outcome of the studies, and this also applies to studies within the category of CBT (Weisz et al., 2006). McCarty and Weisz (2007) suggest that this variability might be attributed to a number of factors such as differences in the skill with which treatments are delivered, variations in study populations, and differences in study design and data analytic strategies. Moreover, the variability could result from the

interventions including different therapeutic strategies or elements despite sharing the same theoretical orientation. Therefore, several researchers have emphasized the need for dismantling studies to identify which components of CBT that are effective (Compton et al., 2004). However, at the present time, there have been few such studies (Kennard et al., 2009).

Central components in CBT. Even though there have been few component-studies on CBT, several researchers have attempted to identify central components in CBT by other means. McCarty and Weisz (2007) tried to identify central components by taking a closer look at the effective treatments for adolescent depression identified in the meta-analytic review by Weisz et al., (2006). In a similar vein, Weersing et al. (2009) tried to review the similarities and differences between three core CBT interventions for depressed teenagers, which vary widely in CBT technique content and emphasis. Two of these interventions, Coping With Depression course (CWD-A) and Pittsburgh Cognitive Therapy, had been documented to be effective (see e.g., Brent et al., 1997; Cuijpers et al., 2009), whilst in the last one, Treatment of Adolescent Depression (TADS), CBT failed to distinguish from the placebo condition (March & Vitiello, 2009). Weersing et al. reviewed (2009) the differences between these three CBT interventions in order to identify potential essential components of CBT in adolescent depression. In general, all CBT programs for adolescent depression target cognitive distortions and behavioral skill deficits (Weersing et al., 2009). However, despite this common orientation, specific CBT interventions vary for instance in the extent to which they highlight the primacy of cognitive or behavioral strategies, and the use of techniques drawn from other therapy traditions (e.g. relaxation-training). The interventions also differ in terms of the total number of sessions, as well as the overall structure of the sessions (Weersing et al., 2009).

Weersing et al. (2009) and McCarty and Weisz (2007) identified many of the same central components in CBT for adolescent depression, but McCarty and Weisz (2007) had some additional components. Whether any of the identified components are necessary to successful treatment remains to be tested, as little is known about which specific components of CBT contribute the most to positive treatment outcomes in depressed youths (Kennard et al., 2009; McCarty & Weisz, 2007). Below follows the central components in CBT as described by McCarty and Weisz (2007), and Weersing et al. (2009). In addition, McCarty and Weisz (2007) found that all the effective CBT treatments focused on having the adolescents achieving measurable goals or increasing their competence in a self-identified area.

Psycho-education. Most CBT treatments start with psycho-education, which involves teaching participants about depression and the rationale for CBT (Beck et al., 1979; McCarty & Weisz, 2007). Psycho-education provides a framework for explaining the mutual interplay between thoughts, feelings, and behavior as they pertain to depression. Psycho-education was identified as a central component by both Weersing et al. (2009) and McCarty and Weisz (2007).

Self-monitoring. Self-monitoring involves the repeated measurement of some target activity or state by the adolescent (McCarty & Weisz, 2007). In CBT, patients are often asked to keep track of daily activities, cognitions and moods. Self-monitoring was not described as a central component by Weersing et al, (2009), but may be seen as included in cognitive restructuring, as this involves some form of self-monitoring of ones thinking. It also may be included in pleasant activity scheduling. Because this is described as a central element by Beck et al., (1979) and McCarty and Weisz (2007), self-monitoring is included this as a central component of CBT.

Cognitive restructuring. As depression is dominated by negative thinking, a central component in CBT is modification of these thoughts (Beck et al., 1979; McCarty & Weisz, 2007; Weersing et al., 2009). Cognitive restructuring involves identifying and altering unrealistic, negative thoughts about yourself, others and different events (McCarty & Weisz, 2007). Several techniques are employed to identify and change the negative cognitions, for instance Socratic dialogue. Cognitive restructuring was found to be a common element among all the CBT interventions (McCarty & Weisz, 2007; Weersing et al., 2009). However, the meta-analysis by Weisz et al., (2006) suggests a similar effect of therapies that emphasized cognitive change and those that did not (e.g. family therapy). This can lead to a discussion of whether or not the cognitive component of CBT is as important as it is thought to be. On the other hand, a review by Garratt, Ingram, Rand and Sawalani (2007) indicates that research generally supports that mediation by cognitive processes is linked to the successful CBT treatment of depression. Furthermore, Weersing et al. (2009) suggest that differences in clinical outcomes could be explained by the extent to which cognitive restructuring is included in the intervention. For instance, the well-documented CWD-A and the Pittsburgh Cognitive Therapy interventions included a significant number of sessions devoted to cognitive restructuring. However, TADS has less focus on cognitive aspects, and the dose of behavioral activation was substantially lower than the dose in CWD-A. Perhaps this could explain the difference in clinical outcome of these interventions; Weersing et al. (2009) speculate that there may be a *dose X technique* minimum threshold for core components of CBT, such as cognitive restructuring and behavioral activation.

Behavioral activation. Depression is often associated with decreased engagement in pleasurable activities and social withdrawal (Fennell, 1989). Behavioral activation involves helping individuals engage in behavior that can elevate mood, as well as helping them to see the relationship between their activity and emotional experiences (McCarty & Weisz, 2007).

As a first step, the patients are often asked to create a daily activity schedule, to get an overview over which activities that give them a greater sense of mastery of pleasure. The next step is usually to increase these activities, frequently called "pleasant event scheduling" (McCarty & Weisz, 2007). This is considered to be a central component by both McCarty and Weisz (2007), and Weersing et al. (2009).

In the adult depression research, Jacobson et al. (2000) did a comparison of the outcome of patients receiving only behavior activation, and patients receiving both behavioral activation and cognitive restructuring. The results showed no difference between these conditions in terms of clinical outcome, thus behavior activation alone provided the same results as when adding a cognitive component. Other studies of adult depression have found that behavioral activation is more effective than cognitive strategies in the acute treatment (Dimidjian et al., 2006), but both components seem to be equally effective in relation to longer term outcomes (Dobson et al., 2008). However, the importance of the behavioral activation component in the treatment of adolescent depression needs to be more thoroughly examined.

Social relationships and communication skills. Another component identified by McCarty and Weisz (2007) is relationship-skills. The aim is to teach participants ways of improving their relationships or interpersonal behavior, as depressed people often have problems in interpersonal relationships (Rao et al., 1999). Examples of skills included in this component are basic interaction skills, social problem solving skills and assertiveness training. Communication skills have been addressed in CBT depression interventions for example by teaching adolescents to express both positive and negative feelings adaptively (McCarty & Weisz, 2007). Relationship and communication skills are not identified as a central component by Weersing et al. (2009). However, Weersing et al. (2009) included a component that included "other techniques" ranging from relaxation training to traditional

family therapy maneuvers, and relationships and communication skills might be included in this.

Problem-solving. Problem solving consists of techniques, discussions, or activities designed to find solutions to specific problems, and are according to both McCarty and Weisz (2007) and Weersing et al. (2009) an important component in CBT. The intention is usually to acquire a set of problem-solving skills which can be applied to future problems. One of the few studies that has explored the impact of specific CBT components on depression outcome, found that CBT participants who received problem-solving and social skills treatment components, were respectively 2.3 and 2.6 times more likely to have a positive response (Kennard et al., 2009). As such, the authors conclude that social skills and problem solving may be active elements in CBT for adolescent depression.

Relaxation-training. In addition to the common components in CBT mentioned above, four of the five effective CBT treatments for depression in the meta-analysis by Weisz (2006) also included a relaxation component. Weersing et al. (2009) mentioned relaxation training as a part of "other techniques" that often are included in CBT for youth. A recent review by Jorm, Morgan and Hetrick (2009) showed that relaxation-training alone is more effective than no treatment in reducing depressive symptoms. While this review did not determine the benefit amongst adolescents specifically, it is likely that relaxation-training can reduce depressive symptoms in adolescents as well. Moreover, this review was conducted on relaxation-training alone, and there is a need for dismantling studies to determine the effectiveness of the relaxation component included in CBT for depression in adolescents.

Homework. Homework-assignments are not described as a central component by McCarty and Weisz (2007) or Weersing (2009), but this is usually considered an essential part of CBT interventions (Beck et al., 1979; Kazantzis & Lampropoulos, 2002). The idea is

that the practice of skills outside of therapy increases the clients' ability to master the skills believed necessary to affect symptoms. Another purpose of having homework is the generalization of skills to their natural setting (Kazantzis & Lampropoulos, 2002). Further, the use of homework-assignments can promote prolonged symptom improvement beyond the completion of therapy. A recent meta-analysis by Mausbach, Moore, Roesch, Cardenas, and Patterson (2010), showed that greater homework compliance was associated with improved treatment outcome in CBT for depression in adults. Little research has examined the importance of homework-compliance on treatment outcome in adolescents, but a study by Gaynor, Lawrence and Nelson-Gray (2006) suggests that homework compliance in depressed adolescents is limited, variable, and likely to decline across treatment.

Group Processes and CBT Interventions in Groups

In addition to considering the common techniques used by empirically supported treatments, an important consideration is the treatment process itself (Shirk & Karver, 2003). In individual therapy, the therapeutic relationship is viewed as important for the outcome. Similarly, nonspecific factors such as group processes might be important for the outcome in CBT groups, but there are significant omissions in the CBT group literature on this matter (Bieling et al., 2006). Many of the group protocols are directly based on individual treatment, and as such neither recognize, nor take advantage of the fact that the group itself creates an environment that either supports or undermines the overall goals in the treatment. Thus, it is important to address questions related to the group process when conducting CBT in groups (Bieling et al., 2006).

One starting point may be in the research on traditional group psychotherapy, which has a long history predating the development of CBT (Bieling et al., 2006). In traditional group therapy, the group processes are themselves the intervention, and the group setting is seen as an agent of change. However, in CBT groups the techniques are seen as the

intervention, and the group is simply the delivery system of these techniques. In spite of the important differences between traditional group psychotherapy and CBT in groups, work on group process factors may offer important insights to group CBT (Bieling et al., 2006).

In the following section, there will de a description of Yalom's (1995) group factors which are relevant for the present study, as he offers one of the most comprehensive perspectives in the group psychotherapy field. Burlingame et al. (2004) have extended his work, and I will briefly introduce their additional factors. I will also illustrate how these factors are relevant to CBT delivered in groups, as Bieling et al. (2006) describes.

Yalom's group factors. Yalom (1995) describes critical group factors, and how each of these can be fostered in the group to produce change. Each of these factors is viewed as being important in a unique way.

Universality is described by Yalom (1995) as the discovery that other people suffer from similar difficulties as one self. This factor might be more pertinent in the group format than in individual therapy, and can possibly alleviate secondary depressive complaints such as "I am the only one in the world who can't cope with this" (Stark et al., 2006). It may also help to create a interpersonal environment that supports group cohesion, which is thought to be important for a positive outcome (Bieling et al., 2006).

Altruism refers to the possibility for group members to help each other, which may be experienced as beneficial both for the helper and the receiver (Bieling et al., 2006). In CBT groups, examples of altruism may include offering alternative thoughts. Stark et al. (2006) notes that it often is easier for children and adolescents to identify and change negative thoughts in others. Moreover, the identification of negative thoughts in others may make it easier for them to be aware of, and change, their own negative thoughts (Stark et al., 2006).

Another example is helping each other through emotional and social support.

Feedback and support from other adolescents is considered as especially important for adolescents, who are often more oriented towards peers than adults (De Goede, Branje, & Meeus, 2009; Furman & Buhrmester, 1992; Weisz & Hawley, 2002). This can be viewed in relation to the fact that they struggle to establish autonomy from their parents. The group format provides unique opportunities for feedback and support from peers (Rosselló, Bernal, & Rivera-Medina, 2008).

Socializing and *imitative behavior* are seen as two important factors by Yalom (1995). These factors are directly based on the work of social learning theorists, including Albert Bandura. In a CBT group, each group member can learn by observing the behavior of both other group members and their leader. For instance, they can learn effective interpersonal strategies. In addition, many CBT interventions includes communication and socializing skills as a part of the intervention (McCarty & Weisz, 2007). The group format gives unique opportunities to foster these abilities compared to individual psychotherapy. A related topic is the possibility of participants learning from each-others experiences. For instance, White (2000) argues that homework might be particularly valuable in a group setting because of the opportunity to learn from the experiences of a variety of people.

Yalom (1995) views *group cohesiveness* as a critical ingredient in the process and outcome of every group, and can be seen parallel to the importance of the therapeutic alliance in individual therapy (Burlingame, Fuhriman, & Johnson, 2002). Group cohesion is a complex phenomena, and described as the attraction the members have for the group and the other members (Bieling et al., 2006). The key ingredients in cohesiveness include acceptance, support and trust of the other group members. Moreover, the level of cohesion is seen to affect almost all interpersonal aspects of group processes (Bieling et al., 2006).

Cohesion has traditionally been seen to occur around the group, but it could be extended to encompass the CBT approach in itself (Bieling et al., 2006). For example, group

members who are enthusiastic about the techniques are likely to reinforce each other. Moreover, when cohesion is high, it is not uncommon for group members to exchange phone numbers, and meet after the therapy has ended (Yalom, 1995). In a CBT group program for depressed girls between 9-13 years; "ACTION", they found that several of the group members became friends after the program was finished (Stark et al., 2006).

The concept of group cohesiveness has been among the most studied aspects of group processes (Bieling et al., 2006). In general, the consensus has been that cohesiveness promotes positive outcomes in group psychotherapy, but in a review by Hornsey, Dwyer and Oei (2007) they state that the empirical evidence for this notion is limited. They argue that the term cohesiveness is too vague and amorphous to be useful as a unitary construct, and that the field could benefit by identifying more specific group processes that facilitate, or impede, clinical outcomes (Hornsey et al., 2007).

Bieling et al. (2006) regard the following two factors as less relevant for CBT, because they are viewed as antithetical to CBT models and therapeutic strategies. However, they will be introduced as they have some relevance for CBT groups. The first one is *catharsis,* and according to Yalom (1995), a group that does not involve catharsis is unlikely to provide the proper conditions of change. Most CBT practitioners argue that catharsis alone is not especially useful, but it's certainly important to disclose some troubling thoughts and emotions. However, this is usually seen as a first step towards modification of these problems, and not an end in itself (Bieling et al., 2006).

Yalom (1995) believes that the participants in the group and the leader can offer *corrective recapitulation of the primary family group*. He regards the group as constituting a social microcosm, where the interpersonal patterns of each member will emerge and interact. This social microcosm may provide opportunities for corrective interpersonal experiences, for example by receiving feedback from others on how one is perceived and one's way of

interacting. Ideally this feedback may help his or her interpersonal functioning to become more flexible and adaptive.

In CBT groups, however, the focus is primarily on "here and now", and not on problematic attachment experiences early in life (Bieling et al., 2006). Nevertheless, CBT groups may address adverse early experiences in a less direct manner. For instance, CBT strategies concerning unraveling dysfunctional assumptions can involve an examination of the origins of such beliefs. However, this is to show how such assumptions may be learned through experience, rather than re-experiencing or interpretation of such experiences. Dysfunctional assumptions concerning oneself as well as other people, can be "tested" in a group environment, and thus potentially provide new experiences (Bieling et al., 2006). For example, the fact that others show understanding of one's situation, and are supportive, can contradict negative thoughts such as "nobody likes me" or "nobody cares about me" (Stark et al., 2006).

Burlingame et al. (2004) have extended Yalom's work, and added three factors that can affect the outcome of group interventions: the structure of the group context, client characteristics and leadership. Structural factors include for instance, dosage, group size and the setting in which the treatments takes place (Burlingame, 2010). Client characteristics such as pre-therapy expectations, comorbidity, intellectual abilities, attachment style and empathy are also important to consider (Burlingame et al., 2004). The model by Bulingame et al. (2004) also points to the importance of the leader. However, few CBT protocols make explicit recommendations about leadership style (Bieling et al., 2006). It is often assumed that the leader should be similar to the therapist in individual CBT, and levels of warmth, openness and empathy have been shown to predict cohesiveness and outcome (Burlingame et al., 2002). However, Bieling et al. (2006) postulate that CBT group leaders need additional skills that arise from the unique group context. Moreover, due to reasons such as

availability and cost of professional instructors, many CBT group interventions use paraprofessional group instructors (Montgomery, Kunik, Wilson, Stanley, & Weiss, 2010). While one could question whether this compromises the quality of such interventions, a review by Montgomery et al. (2010) suggested that paraprofessional therapists can be effective in delivering CBT to people suffering from symptoms of anxiety and depression. Some data suggested a slight advantage in outcome for professionals (e.g., Bright, Baker, & Neimeyer, 1999), but paraprofessionals generally achieved comparable overall outcomes. However, more research is needed on this matter (Montgomery et al., 2010).

Disadvantages of the group format. The group format has many advantages, some of them described previously. The most important one is probably the potential cost-effectiveness of the group-format (Tucker & Oei, 2007). However, there are also important limitations and challenges in conducting CBT groups.

Perhaps the most important limitation of the group format is that there is not as much attention directed at the individual, and this may make the treatment less intense (Stark et al., 2006). The instructor must divide the time between participants, and it may be difficult to keep all the participants engaged at each meeting. If there is too much focus on one participant, the others might be bored if the discussion point is not personally relevant for them. Therefore, it is important to distribute the time between the participants as equally as possible (Stark et al., 2006).

The group format may be challenging for the instructor, who has to keep track of many things at the same time (Bieling et al., 2006). For instance, the instructor has to keep track of group processes in addition to learning specific techniques. Moreover, cognitive restructuring might be difficult in the group format, because it takes time and individual attention (Stark et al., 2006). As mentioned previously, this can be experienced as boring by the other group members, and it can be uncomfortable for the participant in focus.

Another possible disadvantage may be that the participants do not get along with one another, or that they know each other in advance and have a history of conflict (Stark et al., 2006). This can contribute to lack of cohesion, which may have a negative effect on the outcome (Bieling et al., 2006; Hornsey et al., 2007). A third possible disadvantage is that the gathering of depressed people in a group setting could cause a spiraling of the depressive symptoms, and the patients becoming worse (Bieling et al., 2006). When difficulties occur, group factors, rather than the CBT model of intervention, are often responsible (Bieling et al., 2006). But aside from specific process variables, CBT groups can also function poorly due to client factors, structure and leadership.

It should be noted that many of the advantages and disadvantages the group format are at present not confirmed by empirical evidence (Hornsey et al., 2007), and that more research is needed concerning this aspect of early interventions for depression.

The Client's Experience in Clinical Interventions

Elliot and James (1989) state that one can better understand the process and action of psychotherapy if the types of experiences the clients have in therapy are considered. Research has shown that there sometimes is a disagreement between the client's and the therapist's perceptions regarding experiences of therapy and other aspects of mental health care (Bøgwald, 2001; Elliott & James, 1989). However, although the client's experience is acknowledged as important, the client's viewpoint has generally not received much attention (Hodgetts & Wright, 2007; Macran, Ross, Hardy, & Shapiro, 1999). There are several reported reasons for this, including the clients being unaware of the therapy usefulness, being unable to make accurate judgments, biased reporting, poor recall, and difficulties with articulation and expression (see Hodgetts & Wright, 2007). Moreover, there has been a predominance of the traditional positivist paradigm in research with its emphasis on reliable,

quantitative measures, at the cost of an in-depth understanding of personal experiences and meaning (Messari & Hallam, 2003).

In the past years however, there has been an increased focus on gaining knowledge about how the clients perceive psychological interventions (Hodgetts & Wright, 2007). To this date, there have been few studies which have examined how clients experience individual and group CBT, but there are some. For example Newton, Larkin, Melhuish & Wykes (2007) examined how young people experience group CBT as an early intervention for auditory hallucinations. They identified two superordinate themes in their results, of which one is relevant for this study. This is the theme "A place to explore shared experiences" (Newton et al., 2007). Within the mindfulness tradition, there seem to be more qualitative studies on the patients' experiences. For instance, Finucane and Mercer (2006) found in their study on mindfulness-based cognitive therapy in groups, that "being in a group" was an important aspect of the patients experience.

By examining how adolescents experience interventions, one can perhaps make them more attractive, acceptable and effective for adolescents. Thus, the focus of the present study is thus to explore how adolescents experience a CBT group course for depression, more specifically how they experience the specific components as well as the group aspect.

Method

In the present study, adolescents who had participated in CBT group course (Depresjonsmestring for ungdom/Coping course for adolescent depression) were interviewed about their experiences. In the following section, the intervention will be described followed by a delineation of the present study.

The Intervention

The course has a similar theoretical framework as an established intervention for coping with depression in adults (see e.g., Dalgard, 2004). According to Børve (2010), the

course is based on CBT, primarily the work of Ellis (1987) and Beck et al. (1979), but also meta-cognitive therapy as described by Wells (2008). However, the course has a main focus on changing the *content* of negative thinking as described Beck et al. (1979). There is not much emphasis on the changing of the *relationship* to one's thinking that characterizes meta-cognitive therapy (Wells, 2008). Therefore, Beck's version of cognitive therapy has been introduced as the theoretical framework of this paper. Moreover, the course also includes some behavioral elements, such as behavioral activation.

Components in the Intervention

Psycho-education. Psycho-education is a central part of the first sessions. The course starts with psycho-education about depressive symptoms, as well as the relationship between thinking, emotional experiences and actions, and how emotions such as sadness and anger can arise. To illustrate this, the ABC model, described by Ellis (1987) is used. This model demonstrates how the emotional consequences (C) of an activating event (A), is influenced by a belief (B), or the interpretation of the event. How dysfunctional assumptions, and subsequent negative expectations form negative automatic thoughts are further described. The possibility of altering your emotions through behavior is also mentioned.

Self-monitoring. Self-monitoring is introduced in the first session, especially in the homework-assignments. However, self-monitoring is used throughout the course. For instance, the participants are asked to identify what they say to themselves in different situations, as well as monitoring what characterizes both uncomfortable and pleasurable situations. One of the stated goals is becoming more aware of what characterizes different situations in terms of their thinking, emotions and behavior.

Pleasurable activities. Seeking pleasurable activities is primarily addressed through the homework-assignments. The participants are encouraged to seek pleasurable activities at least four times a day.

***Relaxation training*.** The relaxation-exercises are also primarily addressed through the homework-assignments, and include progressive muscle relaxation as well as visualizing a safe place or a pleasurable experience. From the second session, the relaxation-techniques are a part of the homework following every session.

***Cognitive restructuring*.** Cognitive restructuring is presented thoroughly in the third session, with a focus on emotion-regulation through cognitive restructuring. The goal is to become aware of the possibility of regulating emotions by critically evaluating the though content, and replacing negative thinking with positive. Cognitive restructuring and focus on positive thinking is essential throughout the rest of the course, and the ABC-model is used to aid the process of changing thought content. Cognitive restructuring is a frequent part of the homework-assignments in the last sessions of the course.

***Social relationships*.** The fifth and sixth sessions are partly about social relationships, and how these might be affected by depression. The importance of maintaining social relationships when depressed is emphasized, as depression often is associated with decreased social activity. Assessment of what characterizes negative social relationships, as well as some training in social skills is also a part of this component.

Format, duration and structure. The course is conducted in groups of approximately 8-10 adolescents of both genders. It consists of eighth consecutive weekly sessions of 2.5 hours, with a half hour break midway through the session. In addition, two follow-up sessions are conducted 3 and 6 weeks after the last session. In general, the sessions are at the same time every week. Each session has a specific topic associated with the components described above, and related general goals. The sessions usually start with a summary of the previous session, and a review of the homework-assignments. The last sessions focus on how to cope with depressive symptoms in the future by the cognitive and behavioral techniques learnt at the course.

Instructors. To be an instructor, at least three year of relevant education in working with mental health among children and adolescents is required. This includes for example medical doctors, psychologists, social workers, teachers, nurses etc. The instructors have to attend a five-day training program before they are certified course instructors. This is conducted by a trained psychologist, specialized in cognitive therapy and in conducting these kinds of courses. The training program has five parts: 1) mental health and depression amongst adolescents, 2) cognitive theory and method, 3) cognitive methods used in the course, 4) educational approaches or techniques, and, 5) working with the system around the adolescent – such as schools and parents.

Recruitment. The participants are recruited through their General Practitioner, the Schools Health-Service, Public Health-Nurses, Educational and Psychological Counseling Services (PPT) or Child and Adolescent Psychiatric Polyclinic Services (BUP). There should be established a co-operation with the referring agency, to assure that the participant is getting the necessary follow-up after the course.

Inclusion and exclusion criteria. The target population is adolescents aged 14-20, who have subclinical depression or mild to moderate MDD, according to the diagnostic criteria of DSM-IV (APA, 1994). To be included in the course, one also have to have normal intellectual functioning, and normal reading abilities to be able to read the course martial.

Exclusion criteria are the presence of bipolar disorder, psychosis, substance-use, ADD or ADHD, and brain damage. Adolescents who are easily agitated or lacking the ability to function in a group are also excluded. The presence of serious MDD and danger of suicide are also considered exclusion criteria for participating in the course. The course-instructors do a thorough assessment of the possible participants before they are included in the course.

Course-material. Participants are given a relatively extensive course pamphlet, which include descriptions of the different session as well as different kinds of related exercises. The course-material also includes a manual for the instructors, and a pamphlet the participants can give to their teacher(s) and parent(s). This pamphlet includes a description of the course, as well as its' theoretical foundation.

Evaluation of the intervention. Centre for Behavioral Research at the University of Stavanger is responsible for conducting an evaluation of the intervention, which this study is a part of. The larger study is designed as a randomized controlled trial, with a waiting list control group receiving the intervention after the waiting period. Beck Depression Inventory (BDI; (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) is used to measure depressive symptoms and is administered three times to the intervention group; before, at the end, and six months after the intervention. In addition, the waiting list group is measured with BDI when the waiting period begins. Other measures on motivation, school functioning, academic achievements and relationships with peers are also included in the evaluation. Participants are still being enrolled in the study, and thus the results are not available yet.

The Present Study

Recruitment. A total of eight courses were conducted at different locations in Norway during winter and spring of 2010. Originally, the informants were recruited from two randomly selected courses, but few participants volunteered to be interviewed at these courses. Consequently, informants were also recruited from two additional randomly selected courses.

The project-leader contacted the course-instructors asking them to invite participants to take part in the interview study. The course-instructors were given information about the present study, as well as how they should request the participants to take part in it. The course-instructor informed all participants at their course about the interview study and its

purpose, and then invited them to participate. The participants were also given an information-sheet and a consent form, in which they had to sign if they wanted to participate in the study. This was sent to the project leader, who forwarded the contact information to the interviewer.

A total of 30 course-participants were invited to take part in the study, and 12 consented (40 %). Ten of the twelve adolescents who consented to participate, eight females and two males, were finally interviewed (33 %). This was due to unsuccessful attempts to get in contact with two of the participants, which could be related to that the interviews in part were conducted during the summer holiday (June to August 2010).

Participants. Of the ten adolescents interviewed, one of the females was excluded due to a diagnosed bipolar disorder. There were three informants each from two of the courses. From the remaining two courses there were one and two informants.

The participants' age ranged from 17-20 years, with a mean age of 18.4. Most of the informants were interviewed after the last session in the course, but three of the informants were for practical reasons interviewed a few days before the last follow-up session.

The interview study. After consenting to participate in the study, the informants were contacted by the interviewer. Four of the interviews were conducted face-to-face, while the remaining six were conducted by telephone, due to the localization of the informants. Before the interview, the informants were informed about their right to withdraw from the study at any time, and were assured that they would not be identifiable in the research paper.

The aim of the interviews was to provide descriptions of the participants' experience of the intervention. A phenomenological, descriptive, qualitative study design was therefore applied. The present approach to qualitative method was inspired by transcendental or psychological phenomenology as described by Moustakas (1994), and theoretical thematic analysis which allows the use of a priori theory (Braun & Clarke, 2006).

The data was collected by means of a semi-structured interview, which was developed in association with the main supervisor. This was to better ensure that the interview contained the necessary elements to capture the informants' experience of the intervention. The interview guide (see appendix B) was developed on the basis of the course-manual and central components identified in the CBT literature (e.g., Weersing et al., 2009), thus providing a theoretical framework for the interview-guide. Furthermore, the interview-guide contained questions related to how the informants perceived the specific components of the intervention, as well as the group aspect. When considering each of the components, the informants were first asked a general question: "How did you experience this part of the course?", followed by more specific questions, asked to better grasp the informants' experience. Follow-up questions were for instance used to check if the interviewer understood what the informants were conveying.

The interviews lasted between 45 to 80 minutes and were audio-taped and transcribed verbatim. The study was approved by the Regional Committee for Medical and Health Research Ethics (Region West).

Analysis. The verbatim-transcribed interviews were analyzed with assistance of the software program QSR-NVivo 8 (QSR, 2008). The analysis was predominantly descriptive rather than interpretive, as inspired by Moustakas (1994) transcendental or psychological phenomenology. This type of phenomenology focuses less on the interpretations of the researcher and more on the description of the informants' experiences, compared to hermeneutical phenomenology (Creswell, 2007). Furthermore, influenced by theoretical thematic analysis, each of the informants responses were first categorized according to the components in the course, which became the higher-order categories. The content of the components were then categorized in subcategories according to the identified clusters of meaning. Thus, the analysis process was a combination of a deductive and an inductive

method. The coding process of the subcategories was dynamic, continuously moving between data and themes, reorganizing the identified clusters of meaning, while removing other themes. Moreover, the transcripts were read through several times, to better secure the reliability of the analysis.

Results

Description of the Participants

All of the informants reported current or previous depressive symptoms. When the course began, six of the participants experienced themselves as being depressed, two did not consider themselves as depressed, while one was uncertain. Seven of the informants also reported having symptoms of anxiety presently or previously.

Pre-course BDI scores for the interview-group (N=9) were: Mean=26.8 (range 12-44, *SD*=10.69), median 26. The corresponding scores for the other participants at the four courses the informants were recruited from (N=20) were: Mean=18.9 (range 7-32, *SD*=7.24), median 18. Neither the difference in mean scores, tested by independent t-test (p=.11), nor the difference in median scores, tested by the independent samples Wilcoxon signed ranks test (p=.68), was statistically significant.

Post-course BDI scores for the interview-group (N=7) were: Mean=16.1 (range 5-33, *SD* =9.99) and median 14. The corresponding scores for the other participants at the four courses (N=14) were: Mean=12.6 (range 0-30, *SD* = 10.91) and median 9.5. Tests of pre-post changes by paired sample t-test and related sample Wilcoxon signed ranks test indicated statistically significant reductions in BDI-scores for both groups. P-values were almost identical for the two groups, and, were .01 for the t-tests and .02 for the Wilcoxon tests.

Four of the informants received treatment with antidepressants while participating in the course. Two reported very good effect of the antidepressants, while the others said they were somewhat helpful. Two of the participants also used medications for sleeping.

Six of the informants had previously consulted a psychologist, primarily due to depressive complaints. Two had only seen the psychologist for one session, two went for regular sessions for a few months, whereas the final two had undergone treatment for over a year, one simultaneously with the course. At least two of the informants were familiar with many of the general principles of CBT before they started the course. Of the other informants, one previously went for regular conversations with a public health-nurse, and one had had one session with a counselor.

Most of the informants were still in high school. Four went to general high schools, whilst two of them had vocational training. Two of the informants were one year delayed in their education. Another two of the informants did not go to school at the time of the course, at least one of them due to problems related to depression.

There were no noteworthy differences in terms of distribution of age, gender and type of education between the group that consented to be interviewed and the other participants that were invited to participate in the interview-study.

Expectations and motivation. Most of the informants did not have any particular expectations about the course beforehand. This might be related to that this was the first time the course was arranged, and most of them did not know a lot about the course in advance. Another reason might be that many of the participants were encouraged to participate, and did not seek out for help themselves.

I didn't really have any particular expectations [to the course] *because it was a coincidence that she* [the public health nurse] *mentioned it. It was not why I went to visit her*

office, so she mentioned it because I had been in contact with Educational and Psychological Counseling Service (PPT) previously. (I1)

A few of the informants said that they had expectations about meeting people in a similar situation. Others hoped that the course would help them get better, but did not have very high expectations. Only one reported high expectations, because she had previously been in a psychological treatment with cognitive elements.

Most of the informants reported to be quite motivated for the course in beforehand.

I had decided that this was going to work, so my motivation was quite good. I was tired of the feeling of never being happy, so I wanted it to work. (I2)

Another one said that she was not especially motivated:

The problem was that I lacked the motivation to do a lot of things, and that [motivation] *was what I was trying to find trough it* [the course]. *So I don't know how my motivation was. It was there, but I don't know how hard it was burning inside of me.* (I6)

Even though the informants reported being motivated for the participating at the course, many of them did not attend all sessions, due to different reasons.

Psycho-education about Depressive Symptoms

Recognition. The informants found the information about depressive symptoms easy to understand, many of them because they recognized and had experienced the symptoms.

I recognized the symptoms of depression, so I understood it. (I10)

All of them [symptoms] *were quite logical. The only thing I can recall is that I recognized all of them, except the one where you feel sad all the time*. (I8)

However, one said it was hard to recognize many of the symptoms. Another one did not feel that they went thoroughly enough through this material, and that more time should have been spent on this part.

Increased awareness. A few reported that they had not been aware of the symptoms of depression before being informed about them at the course.

It is a bit strange when you haven't thought about it before. Because I was not able to notice that I was depressed before I was in a black hole and couldn't get out of there. Now I am more aware of things that I can recognize with myself, and that was probably the advantage of going through this [the course]. (I1)

Other informants also expressed increased awareness of the symptoms after taking part in the course. For instance several of the informants mentioned that it was easier to recognize the symptoms after the course. Another informant said that it was important that this information is conveyed because not everybody is aware of the symptoms of depression.

Perceived usefulness. Several of the informants experienced that it was easier to recognize the symptoms with yourselves and other people, and this was perceived as very useful. A few reported that this had enabled them to do something about the symptoms.

I see when things start to go downwards now. I realize that I have to think about something different again, instead of just sitting there. (I2)

In contrast, another informant felt that the information about depressive symptoms was not new, and therefore not especially useful. She had seen a psychologist for a year before entering the course. Another informant reported that this information and the course in general, probably would have been more useful if she had not been so weary and had paid more attention to it.

Psycho-education on the Relationship Between Thoughts, Emotions and Behavior

Understanding. Most of the informants found the psycho-education on the relationship between thoughts, emotions and behavior easy to understand and well conveyed. However, one of the informants said:

…it was difficult to understand because I hadn't thought about it before. I didn't know that it worked in that way, that there was an intermediary. So it was perhaps not so difficult to understand, but difficult to accept because I'd always thought that what you feel is natural and right. (I6)

Another informant also reported that this information was a bit strange in the beginning, but that it was easier to come to terms with after a while.

Disagreement about the information conveyed. In one of the courses, some of the informants reported disagreeing with the information that was conveyed. They remembered the course-instructor conveying that you are responsible for changing the way you feel, by changing the way you think about things. In other words, other people and their actions are not responsible for how you feel. These informants felt that this was difficult to accept, because they had experienced many adverse events, which they considered in part to be the reason why they were depressed.

There was something we argued a great deal about, and this was all of the participants at the course against the course instructor. At least, that's what I felt it was like. It was the fact that you are responsible for fixing it [the problem]. *I doesn't matter what the people around you, do to you, it is your problem to solve*. (I1)

One of these informants reported that this message made her feel like it was her own fault that she was depressed, at least at the beginning of the course. She had been bullied for several years.

..the first thing that came to mind was: "Was it my fault then?", "Was it me who was stupid and disgusting?". I feel that it is a natural reaction that you feel sad, if you get called such kind of things. And if you hear it enough times then you believe in them too. And then I mean that it's probably not my fault, what else should I think? (I1)

This informant also reported deterioration of depressive symptoms at the beginning of the course:

I1: *At one period, I felt that I got worse by being at the course. I felt worse when I left the course that day, than when I came. But it was because the course was very strenuous, and because it started in February, which is the worst month there is. So it was hard to separate if it was because of the course, or if it was something else.*
I: Why do you think you got worse?
I1: There was a lot to think about, and a lot of things you thought were different than you now learned that it was. I felt I got a lot of responsibility for why I was depressed. And in a way you were sitting there and saying "I can't help it, I didn't do it on purpose".

The others did not express feelings of guilt, but still disagreed with the information that was conveyed in this part of the course.

Perceived usefulness. Despite some disagreement concerning this information, all of the informants reported that it was very useful to get it.

I thought it was brilliant, because then I understood how fast you could change the way you were thinking, and thereby get another state of mind. (I2)

I think it has been reassuring [to get knowledge about this]*, because when you have knowledge about something, you have more power over it*. (I10)

However, one was more modest about its usefulness:

Yes [it is useful]*, but of course it's not medication, it's not really healing. It's all about how you use it yourself*. (I6)

Identification of Thoughts

Most of the informants thought it were quite difficult to identify their own thoughts, at least in the beginning. Some thought that even though it got easier after a while, it was still quite difficult. Only a few felt it was easy to get hold of their thoughts. One of the informants described her experience of identifying thoughts like this:

I haven't used it so much [identification of thoughts]*, because of the way my days are. Before the course my days were pretty bad, but now it's more up and down, up and down all the time. It's like I can't get hold of my thoughts*. (I5)

A few experienced it as especially difficult to separate their thoughts from their feelings.

I struggled a little with separating thoughts and feelings from each other in the beginning…For me the feelings and thoughts were all mixed together, and I thought it was a bit difficult. (I8)

Use and perceived usefulness. Most of the informants uttered that they used identification of thoughts a lot in their daily lives.

Yes, I do [identify thoughts]. *Because, I still have negative thoughts in certain situations, but now I can notice it and I know that I can think differently. So, it's a bit easier then. (I8)*

Some reported that they used this somewhat.

..it's not always that I remember it. I try to remember it and use it as often as possible in everyday life…But trying to learn it is quite difficult. (I9)

One of the informants said that it takes a lot of energy to try to identify you thoughts, and because of that, she did not use it as much. She expressed that she could have used it more.

But when you feel like crap, you don't really feel like doing that [identifying your thoughts]. (I1)

As for perceived use, everybody thought it was useful, to some degree, to be able to recognize their own thoughts. However, some expressed both positive and negative aspects of identifying their own thoughts.

It can be both helpful and unhelpful. Sometimes when I notice them [the thoughts]*, they're not so positive, and it's not always that I can do something about them. So sometimes it gets worse, but mostly it gets better*. (I4)

Cognitive Restructuring

Most of the informants found it hard to find positive thoughts, but in general most of them stated that it got easier after a while.

It wasn't easy [to find positive thoughts]. *My positive thoughts come when positive things happen, and if I have a day where a lot of negative things happen, it is very hard for me to find something positive that day*. (I5)

One of the informants said that she got the impression throughout the course that you were not supposed to experience negative emotions, perhaps because of the focus on positive thinking:

I: Did you get the impression that you're not supposed to be sad throughout the course?

I6: Yes, a little, but I think it is good to be sad sometimes. So, if I feel that I behave irrational and if I feel angry without a reason, then I can change it. But if I feel sad because of a legitimate reason, e.g. that someone has done something unreasonable to me, or I have lost someone, then its okay.

However, in another part of the interview she said that the course did not convey that what they were feeling was not right, but that one can do something about the way one feels. In a way this contradicts the quotation cited above, were she got the impression that she was not supposed to feel sad.

Use and perceived usefulness. Some uttered that they used cognitive restructuring a lot, while most of them said that they used it sometimes. For most of the participants, cognitive restructuring was the most frequently used of the techniques they learned at the course. Still, several found it somewhat difficult to use in everyday life.

It was not really difficult to understand [changing thoughts]*, but it is difficult to use*. (I8)

Another informant said that it was not so hard to find positive thoughts, but to believe in them:

I6: *It's easy to say something different to yourself there and then, but I don't know how well it's going to work in the long term…It's not difficult to find [positive] thoughts, but it's difficult to use them.*

I: *Did you find it hard to believe in them?*

I6: *Yes. And it is difficult to change your way of thinking when you're used to thinking in one way for so long. It's like jumping out of the circle*.

A few also uttered that they often used activities or distraction as a strategy for alleviating depressive symptoms, rather than changing their thinking.

I: Do you use positive or alternative thoughts today?

I1: Yes. But if I'm very depressed one day, I'd rather work out even though I don't really want to.

Even though many thought it was difficult to find positive thoughts, and to change their thinking in everyday life, all but one regarded the cognitive elements of the course as the most useful. However, they emphasized somewhat different aspects. Two said that it had been most useful learning about the negative automatic thoughts.

I think it was the negative automatic thoughts because I understood that much depends on how you look at situations. And I think that has changed a lot about how I view things. I've become much more positive afterwards. And then we had different ways to view things, such as black and white thinking. I used black and white thinking a lot before. But that changed when I understood that it didn't have to be like that. (I2)

This informant also emphasized the usefulness of learning about errors of thinking. Several other informants said that they regarded the ABC-model as one of the most useful elements in the course.

Even though I haven't used it so much, I think the ABC-model is useful. And recognizing feelings is also useful. And when you have the feelings you should ask yourself if the thoughts you're having, are useful, and, if you should have them. I thought that was very useful. For instance, if I'm sad I can ask myself: "Should I be sad because of this?". That has helped me in that I don't lie there and cry myself to death. (I5)

Others said that the most important part of the course was learning cognitive restructuring. In summary, most of the informants report that they experience themselves as more aware of their own interpretation and experience of different situations, and that this interpretation is one of many possible.

I: What do you think was the most useful about the course?

I6: It was becoming aware of the thoughts, or not becoming aware of the thoughts, because that was the hardest part. But becoming aware of how it works; a situation, an interpretation and then a feeling…That was great, because then you learned to discuss with yourself, and that has been very useful in many situations…

Relaxation-training

Some of the informants uttered that they did not really need the relaxation-exercises. A few said that they already had relaxation-exercises that worked well, another one that he usually was relaxed so he did not need relaxation-exercises.

Progressive muscle relaxation. Only one of the informants said that she used this technique a lot, and found it very useful. Two said that they used it sometimes.

I'm not very fond of relaxation-exercises, I relax better with music and a sofa. But it helps if I'm having a test or something, and I have used the breathing exercises when I'm at the dentist, because then I'm more relaxed. (I2)

However, most of the informants said that they did not use this technique at all. A few of these had other relaxation-techniques that they used. One of the others expressed:

I: Is there any particular reason why you haven't used it?

I8: Well, I think it takes too long, and you're supposed to tighten all the muscles in the body, and I find that a bit strenuous.

I: So you don't think it works well for you?

I8: No, I don't think I have the patience.

Another one said that she had not tried the relaxation-technique, because she wanted to do the exercises at the course. However, several of the other participants expressed that they did not want to do the exercises in front of the others. Another informant also mentioned that there could be more practical exercises, such as relaxation-training, at the course.

... I'd like to do it in a group, with someone. I didn't want to sit at home and do it. Of course I have to do it at home after a while, but I wanted to try it there first. (I5)

When it comes to usefulness, only a few reported this as useful. However, one of these informants said that she used progressive muscle relaxation the most of all the techniques learned at the course.

..I spend a lot more time relaxing [than before]. *I've always been doing a lot of things, and never relaxed. If I were at home, I got bored very easily, and I had to go out and do something. I never took the time to relax, but now I can sit and think about things without getting scared about thinking. The relaxation-technique is great when you are in a stressful situation.* (I6)

Moreover, while some informants voiced that this relaxation-technique could be useful in the future, others felt it was not useful at all.

Visualizing a safe place or a good experience. Most of the informants had not used this technique, some of them because they did not really need it. Others could not remember this exercise, but these had been absent at least one of the sessions. Another one told:

No [I haven't used it]*, because it only makes me more depressed. Then I think "I'm not in that period anymore". So that's not something that I should not do*. (I5)

Some informants described that they had used it sometimes.

I: What kind of situations have you used it in?
I8: If I'm in a situation where I'm very nervous or tight, I've tried to use it to calm down, and focus at something else. (I8)

Only a few informants found the technique useful.

Yes, it's lovely to daydream. And in a way it helps on your motivation too. Because you visualize a place where you want too be, and in a way you meditate into that place. Then it doesn't seem so far away, and you get motivation to get to that place. (I6)

Pleasurable Activities

Increased awareness. Several expressed that they had become more aware of what makes them happy, and that they should do more things that makes them feel that way.

I1: In a way, you are forced to find it [what makes you happy]*, and that's quite good. And we had to write things down, and suddenly I found something that I had forgotten that I liked.*
I: Do you have any examples of that?
I1: Yes, books. I've always liked reading, but I couldn't recall it then. I really love reading.

Use and perceived usefulness. Most of the informants said that they used this knowledge of the importance of taking part in pleasurable activities a lot. This was the most used of the techniques learned at the course for one informant.

I: Is this something that you use a lot [pleasurable activities]*?*

I9: Yes, I try to seek happiness all the time. I am with friends and acquaintances, and that makes me happy.

Many said that they took part in more pleasurable activities now than before the course.

I3: Before I started the course I didn't want to do anything.
I: So you do more things that are fun now?
I3: Yes, I try to find things that I like.

As for perceived usefulness, most of the informants thought that this was very useful, while a few thought that it was somewhat useful.

I was activated and became in better shape, something that helps on both the energy-level and the depression. And there was less time to think when I was active. So it's good in many ways. (I10)

One of the informants said that this part of the course was very short. However, she did not want it to be longer:

They could have focused more on positive thinking. I don't find pleasurable activities as interesting. I think it is much more important with positive thoughts. (I4)

Another one uttered that they had a lot of focus on seeking pleasurable activities, and that they were given an overview of 200 different activities that people often find pleasurable. However, this was not a part of the course-material, but the similar adult-version of the course.

Social Relationships

Some of the informants expressed that they remembered little about this part of the course. A few also said that they could have more about this topic. However, most of them thought that this part of the course was useful.

12: I think this could help a lot of people, because it helped me. So I think this part was very useful.
I: You mentioned that you have become more outgoing after participating at the course?
I2: Yes, I have become more self-confident, and do not think as much about what others might think of me.

Most of the informants said that they are a lot more together with others than before the course.

I5: *I spend much more time together with other people. Before the course, I just went home and straight to bed. Now, I force myself to socialize with friends and acquaintances*.
I: *What's the reason for that?*
I5: *Because it makes me happy, and I want to do more of the things that make me feel that way…*

A few said that they neither spend more or less time with other people.

I'm neither more or less together with others because I think it is difficult to use it [the knowledge]. (I8)

Homework

Some thought that the homework-assignments were easy to understand. However, several of the informants thought the homework-assignments were somewhat difficult.

There were a bit too many assignments, and I did not really know what we were to do. I always did the assignments in the pamphlet, but at the next session I realized that I shouldn't have done all of it. They should have been better at telling us what to do and what not to do. And I didn't really understand why we had the assignments. It was useful, but I thought that the homework-assignment went faster ahead than they did. (I4)

A few of them said that this would be better if they had gone through the assignments in advance. There seemed to be dissimilar practices at the different courses regarding this matter, as other informants reported that they went through the assignments before in advance Some said that they would have liked more examples in the assignments, and:

Maybe use a more simple language, so one can understand it better. I have noticed that there are many technical terms in the assignments. But if it were explained in normal terms, it would be easier to understand. (I9)

Doing the assignments. For various reasons, most of the participants did not always do the homework. One reported reason was a lack of motivation:

I5:..it's okay with homework-assignments, but I can't stand the thought of them. I have probably lost my motivation.
L: What do you think is the reason for that?
I5: When you're home you want to do other things. You don't want to do assignments, which can be boring. When I'm home, I'd rather read a book of own choosing.

Some reported that it was difficult to do the assignments because it took a lot of effort.

I: Was it hard to do the homework-assignments?

I3: No, not really, but we didn't get that many assignments. It was okay, there was nothing negative about them. It just took a lot of effort doing them.

A few thought that the homework-assignments were too time-consuming.

It took too much time in relation to my situation. But I think it is difficult to benefit from them and at the same time spend less time on them. (I10)

The course partially overlapped with this informant's exam-period, which he listed a reason for why he did not do all the homework.

Perceived usefulness. The informants were asked to choose whether the course should include homework or not, in terms of perceived usefulness. Most thought that it was important to have homework, and the course would not have the same usefulness if they did not have these assignments.

I would definitely have chosen it [to have the homework-assignments]*, because you get a better understanding of what the course is about. And you can repeat what you have learned at home, so that you learn it better*. (I8)

However, some of the informants thought that the course would have been as useful without the homework-assignments.

... It's just an extension of the course. I was so tired after the sessions that I didn't really want to start the homework-assignments, which in a way were an extension of the session. (I1)

Group Aspects

Advantages of the group format. In general, the informants reported being in a group as positive.

I was a bit afraid at first. I thought that if you put a group of depressed adolescents in a room, and are going to talk with them about this, it's all going downhill. We will influence each other with negative attitudes and thoughts, as well as positive. But it went very well, and most of them were very nice… (I1)

Normalization. Many of the participants felt that it was very useful to meet people in a similar situation, and experienced what seems like normalization of their difficulties. One described this as the most useful aspect of the course.

I think this was maybe the most uplifting in the beginning [meeting other adolescents in a similar situation]*, because you feel that you are alone, but then you find out that you're not, and that is very important*. (I10)

I thought it was scary in the beginning [meeting other adolescents in a similar situation], *but it became a lot better when I saw that they were completely normal, just like me*. (I2)

Understanding. Other informants reported experiencing a deeper understanding of their difficulties through their interaction with fellow course-participants.

Many psychologists have not experienced depression, they have read about it in a book. I'm not criticizing psychologists, but its nice to have a different perspective. (I10)

Making new friends. One of the informants reported that an advantage of the group format was that one could make new friends.

You can make new friends and extend your social network. (I10)

The informants were asked if they were going to keep in touch with some of the participants at the course, and most of them said yes.

I: Do you think that you will keep in touch with some of them afterwards?
I5: Yes, guaranteed. I am very happy that I met at least one of them. That's very nice…we had something to talk about and something in common.

Different perspectives. Others reported that they experienced that having different perspectives on things as helpful.

…you get a different perspective on things, when other people say something that you haven't though about before. (I8)

Some also described this as helpful in association with finding alternative thoughts.

I3: We were put in groups and got assignments. We were supposed to find alternative thoughts, and then we were to tell them afterwards.
I: So you got some help from the others at the group then?
I3: Yes.

Group vs. individual format. The informants were asked whether they would choose the group format or individual therapy, if they were to choose again. Most of the informants said that they would have chosen the group format. Some of these had previous experience with individual psychotherapy, but just one of these informants had found this somewhat helpful. Why did they prefer the group format?

I tried to go to a psychologist and went there once. I cancelled the next session. It was a lot at one time, I felt like I had to tell my deepest secret in half an hour. (I6)

All of the informants who had previous experience with individual therapy, but preferred the group format, seemed to have experienced individual therapy as too intense. Some of these informants reported it as an advantage that the group format implies a shared focus of attention between all the participants:

The advantage is that it's not so personal. You don't get so much time for yourself, there's not so much focus you only. There focus was on everybody all the time… (I6)

The participants choose themselves how much personal information they wanted to share, and in that way the course was less intense.

Two of the informants said they would have chosen individual therapy if they were to choose over again. These two had seen a psychologist regularly for 1-2 years, and had found it very useful.

..I would say individual therapy. Because in the group you probably benefit from 50 %, but a psychologist alone has 100 % focus at you. (I10)

In general the informants reported few disadvantages concerning to the group format. The informants were specifically asked if there were something that they felt that they could not tell in the group, and most of them did not regard this as a problem.

I felt very safe in the group. But it was on a general level, and not about anyone personally. Then it's much better. (I1)

Disadvantages of the group format. As noted previously, many experienced the group format as less intense than individual therapy. Although many see this as an advantage, some viewed it as somewhat negative, because it could make the intervention superficial:

When we're so many people, there are a lot of things you don't get to go into. I feel that its focus is on the superficial level… (I5)

I got the impression that we were not supposed to dig in the past… when you had things that you had experienced in the past, I felt that you just had to leave them behind. You were just going to say "I'm not thinking right now, I have to think differently about it". *But I*

understand it too, because it is a large group, and everybody can't tell their deepest sorrows and secrets… (I6)

At the same time these informants expressed a preference for the group format over individual therapy. Another negative aspect of the group format mentioned was that it was more like a sorority than a course.

…We had a lot of time talking amongst ourselves. So at times it was more like a sorority than a course… sometimes it was really quite annoying. I said a couple of times, "Can you be quiet now?". And the course-instructor was quite stressed about the whole thing. (I6)

It was also mentioned that it might be difficult to meet the other course members outside the course.

I6: …Meeting the people you have been at the course with at the street, or at a party. It's difficult to relate to these people. When I'm at a party, I'm not there to talk about how many problems I have or how sad I am… For me this was something I talked about at the course, and when someone talked about that in a different setting it's a bit difficult. "What are we going to talk about now then? How well we're doing? Let's talk about that".
I: Do you think there was too much focus on negative aspects?
I6: Yes.

She also mentioned that there was a lot of focus on negative aspects of depression in the beginning of the course, and that she almost became more depressed then. However, this became better after a while.

Duration

Most of the informants thought there were enough course-days. However, some thought the course could be extended.

The whole course could be extended, because there was not much time for each part. It went a bit fast forward. Some people learn more easily than others, and grasp everything. But if I learn new things all the time, I have difficulty remembering things. We should have learnt more of everything, I think. (I5)

A few other informants also experienced the course material being somewhat hard to understand, and as such the course could be extended. When it comes to the duration of the session, everybody thought that 2 ½ hours was a good duration. However, one thought the sessions could be longer if the material was easier.

Recommendation to Others

Everybody, except one, said that they would recommend the course to others who experience depressive symptoms.

I2: Yes, I would absolutely do that [recommend to others]. *Even if you don't have depression, it's brilliant. You understand how you can make a situation different.*
I: So you think it could be useful for many people then?
I2: Yes, especially for girls between 15-18 years of age, where appearances and such things are so important.

However, a few of the informants asserted that it is probably not going to work for everybody.

Discussion

There is great variability in the clinical outcome of CBT trials on adolescent depression, and this may in part be due to differences in content and emphasis on the different CBT components (Weersing et al., 2009). Moreover, gaining insight into the clients' experiences may provide important knowledge of what the clients experience as useful in CBT courses, which in turn may be related to the clinical outcome (Hodgetts & Wright, 2007). Thus, the first aim of this study was to explore how adolescents experience the specific components of an early intervention for adolescent depression, in the form of CBT group course. In general, CBT group interventions seldom take into account the possible consequences of group processes (Bieling et al., 2006), and how the group aspect is perceived by the participants. Therefore, the second aim was to explore how the participants experience the group aspect of the intervention. In the following section, the informants' experiences and perceived usefulness of the different components will be summarized and discussed.

In general, the informants seemed to have experienced the course as beneficial, as illustrated through their responses in the interviews, such as the fact that most of them would recommend the course to others with similar difficulties. This benefit is further supported by the statistically significant decline in BDI scores from pre to post-intervention. However, due to the small sample size and lack of control group, the results of the significance testing of the BDI scores should be interpreted with caution.

The Informants' Experiences of the Core Components of CBT

Psycho-education. Psycho-education is one of the core components of CBT as identified by McCarty and Weisz (2007) and Weersing et al. (2009). In general, psycho-education about the depressive symptoms was perceived as easy to understand because the participants recognized the symptoms. Some said they had not been aware of the symptoms

beforehand, and others reported an increased awareness of the symptoms. The increased awareness of the symptoms was described as useful, because it was perceived as a starting point for doing something about them.

Considering psycho-education about the relationship between thoughts, emotions and behavior, most of the participants also thought that this was easy to understand and well conveyed. However, some experienced that this information placed a lot of responsibility on the depressed individual. They perceived it as though other people and their actions did not have any influence on why they were depressed. This was difficult to accept for these informants as they had experienced many adverse events, such as bullying and rape. The possibility of the clients feeling guilty of their negative thoughts and emotions is one of the potential pitfalls of CBT. The general assumption underlying CBT is that how individuals structure the world largely determines their emotions and behavior, thus giving the client a unique possibility to change their emotional consequences (Beck et al., 1979). However, this also implies being responsible for your own happiness, as one of the informants describes. There is a potential for further reinforcing the vicious circle of depression, if the clients experience it as their own fault that they are depressed. Indeed, two of the informants actually described a deterioration of their condition at the beginning of the course, possibly related to the perceived responsibility for being depressed.

Negative thinking, as well as feelings of guilt and shame, is a part of the clinical picture of depression (APA, 1994; Hayden et al., 2009). Therefore, it is important to be aware of the possibility that issues, such as the one mentioned above, can emerge in CBT interventions. Perhaps it should be made more explicit in CBT interventions that one's early experiences form the foundations of dysfunctional assumptions, as Beck et al. (1979) describe. Moreover, it should be emphasized that everyone has irrational thoughts at times, but in depression there are more of these thoughts (Beck et al., 1979; Ellis & Dryden, 1987).

The knowledge that everyone has these kinds of thoughts and dysfunctional assumptions could possibly alleviate feelings of guilt.

It was, however, only informants at one of the courses who experienced getting a lot of responsibility for being depressed. Thus, this may have something to do with how the course-instructor conveyed this information. One could question whether the training-program for the course-instructors is good enough, and whether one is qualified to lead a group CBT course with three years of relevant education in working with mental health in children and adolescents. However, a review by Montgomery et al. (2010), concludes that paraprofessional therapists can be effective in delivering CBT to people suffering from symptoms of anxiety and depression. This implies that having three years of relevant education in working with mental health should be as effective as being a trained therapist, if they are thoroughly trained before conducting the intervention. Moreover, this training should have an explicit focus on addressing potential pitfalls of conducting CBT-interventions, such as the possibility of experiencing guilt in association with being depressed.

Despite some disagreement concerning the psycho-education on the relationship between thoughts and emotions, all of the informants reported that it was very useful to get this information. This could suggest that although it was difficult for some to accept in the beginning, it was easier to come to terms with after a while.

Identification of thoughts and cognitive restructuring. Identification of thoughts and cognitive restructuring are combined in this section because they can be viewed as overlapping processes. Cognitive restructuring, including identification of thoughts, is probably the most central component in CBT (Weersing et al., 2009). Accordingly, all of the informants, except one, experienced the cognitive aspects of the course as the most useful. However, there was a variation in which aspects the informants emphasized. Some said that

learning about the negative automatic thoughts was the most valuable, others thought it was useful to learn the ABC-model, whilst some emphasized the importance of learning how to change their thinking. Nevertheless, several of the informants mentioned that it was difficult to use the cognitive change strategies in everyday life. Accordingly, only a few of the informants reported using cognitive change strategies a lot, while most said that they used these techniques sometimes. Thus, they seemed to perceive the knowledge about the general principles of cognitive restructuring as beneficial, but experienced difficulty in applying these principles in their lives. A possible reason for this might be that group-based CBT courses of this kind do not give enough opportunity for individual training in the different techniques. Indeed, some of the informants mentioned that the course could be more practical, and that the techniques would have been more useful if they knew them better. Further, individual differences, such as intellectual abilities, may play a part in how easily the participants learn and apply the different techniques (Bieling et al., 2006; Burlingame et al., 2004). Indeed, it was mentioned by some informants that the course material was somewhat difficult, and that the course could be extended. What the appropriate "dosage" of the different components is, may vary among the participants. It may be a challenge for the course instructor to adapt the course to people with different intellectual abilities and ways of learning (Bieling et al., 2006). Thus, it may be difficult for a general course such as this to satisfy the needs of all the participants. This could be one reason for the variability in the informants' experiences of the course. Moreover, motivation could also influence the degree to which the participants applied the techniques. However, most of the informants reported being motivated for the course. Nevertheless, lack of motivation and effort is a part of the clinical picture of depression (APA, 1994), and thus could affect how much the informants used the techniques.

Most of the informants reported changes related to their thinking, which they associated with the course. More specifically, they seemed to become increasingly aware of their individual interpretation and perception of situations, and that this interpretation is one of many possible. This awareness may be interpreted as an expression of increased flexibility in the informants' thinking. Nevertheless, negative aspects of cognitive restructuring were also reported, as one of the informants reported getting the impression that one was not supposed to experience negative emotions. This could potentially lead to an experience of guilt associated with the experience of negative emotions such as sadness and anger. The intervention in the present study, emphasizes positive thinking to counter and replace negative thinking. Perhaps it would be better if "realistic thinking" was used instead of "positive thinking". As Beck et al. (1979) notes, there are important differences between schools of "positive thinking", and CBT. For instance, an obvious problem with "positive thinking" is that the positive thoughts are not necessarily valid or accurate. Indeed, one of the informants reported that she had difficulties believing in the positive thoughts. In "realistic thinking" the focus is on gathering evidence to contradict the distortions, and not on making unrealistic positive assessments (Beck et al., 1979).

The findings suggest that it is important that CBT interventions are more explicit on this matter, as the focus on positive thinking and changing the content of one's thinking could be interpreted as if one is not supposed to feel sad. A similar criticism of CBT has been that it does not have enough focus on emotional experiences, as the main focus is on cognitive aspects (Hougaard, 2004). However, the later versions of CBT have to a greater extent incorporated emotional aspects. The present study's CBT course has a section addressing emotions at the beginning, but it seems apparent that the normality of experiencing different emotions could be addressed more specifically. It is important to convey the normality of experiencing negative emotions in CBT interventions, as well as the

qualitative difference between depression and sadness. In depression, the mind is overpopulated by negative thinking, and it is important to realistically examine the evidence of these thoughts (Beck et al., 1979).

Another related criticism of CBT comes from what is called the "third wave of behavioral and cognitive therapies", for instance Mindfulness-Based Cognitive Therapy (MBCT). Proponents of the third wave argue that the unbalanced focus on changing the content of negative thinking possibly could maintain or maybe even cause a deterioration of depressive symptoms (Segal, Teasdale, & Williams, 2004). Within MBCT, the main focus is on meta-cognitive processes such as changing the relationship to one's thinking, balanced by acceptance-based procedures. It is stated that the present intervention includes a focus on meta-cognitive aspects (Børve, 2010), but it is unclear to what degree this has been addressed at the different courses, as this has little place in the course-manual. Perhaps meta-cognitive and acceptance-based principles could be included to a greater degree in CBT interventions for adolescents, to balance strategies directed towards changing the negative thought content, and thus the negative emotions. Moreover, some of the informants also mentioned that identification of their own thinking could be negative, if they did not manage to change these thoughts. Perhaps an acceptance-based approach could be appropriate to introduce in this context as well.

Relaxation-training. Relaxation training is a central component in many CBT interventions for adolescents (McCarty & Weisz, 2007; Weersing et al., 2009). In the present study, the informants had quite mixed experiences with the two relaxation-techniques, progressive muscle relaxation and the visualization technique. As many of the informants did not use the relaxation-techniques, and few reported them as useful, one could question the necessity of including relaxation-techniques in a CBT course for depression. However, a recent review by Jorm, Morgan and Hetrick (2009) showed that relaxation training alone is more

effective than no treatment in reducing depressive symptoms in adults. But whether or not relaxation-training gives an added benefit on depression-outcome in CBT interventions, remains to be tested. Moreover, even though there were few who found these techniques beneficial, some informants had learned relaxation-techniques previously, which they found beneficial and used frequently. This illustrates that these techniques perhaps are not beneficial for everyone, but are experienced as useful by some depressed adolescents. However, one could question to what degree these techniques were practiced at the course. This is discussed later in association with the group aspect.

Pleasurable activities or behavioral activation. Behavioral activation or taking part in pleasurable activities to alleviate depressive symptoms is also a central component in CBT interventions (McCarty & Weisz, 2007; Weersing et al., 2009). Discussing their experience of this component in the present intervention, several of the informants said that they had become more aware of what make them happy, and that they had participated more in pleasurable activities than before the course. Most of the informants reported this component as very useful. This could indicate that behavioral activation is an important inclusion in CBT treatments for adolescent depression. However, the behavioral activation component has relatively little place in the course compared to other CBT group interventions, for instance the similar adult version of this intervention (see e.g., Dalgard, 2004). This limited the ability to study how the informants experienced this aspect of CBT in the present study. However, only one of the informants reported that this part of the course was very short, although she did not wish to extend it, as she wanted more focus on positive thinking.

Social relationships. Social relationships and communication skills have been identified as core components in CBT (McCarty & Weisz, 2007; Weersing et al., 2009). Most informants in the present study regarded this component as beneficial. However, the results also suggested that this topic did not have a central place in this intervention. Some said they

remembered little about this part, while two of the informants felt that they could have had more about this in the course. In a recent study by Kennard et al. (2009), they found that adolescents who received the problem-solving and social skills components in CBT were more likely to have a positive response. A possible weakness with the intervention in this study is that it does not contain a problem-solving skills component, and has relatively little focus on achieving social skills. However, most of the informants said that they were more sociable than before the course. But whether or not this is associated with the social relationships component is uncertain. It could also be related to the focus on seeking pleasurable activities, as being together with others is something that most people find enjoyable.

Homework-assignments. Homework-assignments are an important part of CBT interventions (Beck et al., 1979), and are related to the clinical outcome (Mausbach et al., 2010). Some of the informants in this study found the homework-assignments easy to understand, but several thought the assignments were somewhat difficult. There seems to be a potential for improving the homework assignments, for instance by using fewer technical terms, and including more examples to the assignments.

For various reasons, including the one's mentioned above, most of the informants did not always complete the homework-assignments. This is a common problem in CBT interventions (Gaynor et al., 2006). Some of the informants reported that it took a lot of effort to do the assignments, and that the assignments were too time-consuming. Similarly, most of them also reported not being especially motivated to do the homework-assignments. It could be that the informants were reluctant to do the homework-assignments because they reminded them of school-activities. Nevertheless, when the informants were asked about homework-assignments in terms of perceived usefulness, most of them thought it was important to include the assignments. On the other hand, it should also be noted that some thought that the course would have been as beneficial without the assignments. Thus, the informants were quite mixed in their

views of the importance of the homework-assignments. There are indications of low homework-compliance, and this could be a more significant problem in CBT groups than in individual CBT. It could be argued that because there is less attention paid to the individual, it is more important that the participants practice the exercises on their own. Thus, it may be especially important to consider ways to improve homework-compliance in these kinds of interventions. However, there is a need for further research to examine this.

The Informants' Experiences of the Group-Aspect

The second main aim of the present study was to explore how the informants experienced the group format. In general, the informants reported being in a group as positive. Most of the informants felt that it was very useful to meet people in a similar situation, which can be related to Yalom's concept of *universality* (1995), the discovery that other people have similar difficulties as oneself. One informant said this was the most useful aspect of the course.

Similarly, some of the informants reported a deeper understanding of their difficulties as a result of conversations or interactions with fellow course-participants who had experienced similar problems. Having a different perspective, and getting help from others in finding alternative thoughts, was also perceived as useful. This could be related to *altruism,* which is emphasized as an important beneficial aspect of the group format (Yalom, 1995). There are few studies on the experience of CBT group interventions, but there are some studies on mindfulness based cognitive therapy (MBCT) in groups that have yielded similar results as the present study. For instance, Finucane and Mercer (2006) found that themes such as being understood, realizing that one is not alone, as well as normalizing experiences were common positive aspects of being in a group.

Another positive aspect of the group format, which the informants reported, was the possibility of making new friends. Most of the informants said that they were going to maintain contact with other participants at the course. This could be an indication of a high degree of

group cohesion, which is believed to have a positive effect on outcome (Yalom, 1995), but there is a need for more research specifically addressing this issue (Bieling et al., 2006; Hornsey et al., 2007). However, it is possible that cohesion could have consequences for the outcome of CBT groups. For example, one of the informants said that she wished that they could do the relaxation-exercises at the course, because she thought that it was easier to do them there. However, she said that several of the participants at the course did not want to do the exercises in front of the others. This could be an indicator of individual differences in terms of how comfortable they were in doing such exercises in front of the others, but it could also be an indicator of low group cohesion. If group cohesion is important in CBT groups as well, low cohesion could affect the outcome in CBT groups negatively (Bieling et al., 2006). In this example, this could imply that the participants did not learn the relaxation-exercises well enough. The group format could entail that the participants need to be more self-reliant than in individual therapy, which might imply a need for participants with a high degree of motivation and self-discipline.

Group vs. individual format: Most of the informants said that they would choose the group format over again. Several of these informants had previous experience in consulting a psychologist, but only one experienced this as beneficial. These informants seemed to have in common that they experienced individual therapy as too intense. Some reported it as an advantage that the course format entails a shared focus of attention between all the participants. The participants decided themselves how much personal information they wanted to share. This could have given them a greater sense of control compared to consulting a psychologist. Thus, the course could be experienced as less intense and less threatening than individual therapy. However, according to Yalom's group factor, *catharsis*, it is essential to share some personal information to have a positive outcome of group psychotherapy, although according to Bieling et al. (2006) this is not viewed as central by most CBT therapists. Nevertheless, it was reported by

one of the informants that the course could be perceived as superficial, because of the limited exploration of individual experiences. The course format entails a limited amount of time devoted to each individual (Stark et al., 2006), as the focus in CBT groups is learning the cognitive techniques rather than going deeply into the problematic experiences of each individual (Bieling et al., 2006). If the adolescents need more extensive help, they are recommended to seek help elsewhere, as the intervention in the present study is an early intervention in a stepped care model. Consequently, these interventions might not be appropriate for everyone, and thus, it is important to have a thorough assessment of possible participants in advance.

Another factor that could be explored in relation to the preference of the group-format, is the developmental stage of adolescents. Given that peers seem especially important in this period (Furman & Buhrmester, 1992), the group-format might be more attractive to adolescents than individual therapy. The group-format gives unique opportunities for feedback and support from peers, which are not obtained through individual therapy. A third possibility is that going to a course is less stigmatizing than going to a psychologist (Clarke et al., 2003), and that this is a reason for many of the informants to choose this format. Furthermore, the fact that many of the informants seemed to prefer the group-format could also be due to a selection-bias. It is possible that the people who would prefer an individual approach would not assign for a group-course.

It should also be mentioned that two of the informants would have chosen the individual format if they were to choose over again. These informants were the ones who had the most extensive experience with psychological treatment in advance, whilst the remaining informants had only limited experience with consulting a psychologist.

The informants reported some disadvantages of the group format. In addition to a few of the informants experiencing the course as superficial, some perceived it somewhat difficult to be in a group, especially in the beginning.

Strengths and Limitations of the Present Study

By using a phenomenological, qualitative approach, one can get a more in-depth account of adolescents experiences, compared to quantitative studies (Messari & Hallam, 2003). Several measures were undertaken to secure that the results were as accurate and valid reflections of the participants' reported experiences as possible. The transcripts were read several times, and the analysis remained predominately descriptive rather than interpretive, letting the informants narratives speak for themselves. Moreover, the analysis process was dynamic, to better ensure that the identified categories represented the informants responses. Another strength of the present study is the inclusion of quantitative measures to give a description of the sample.

However, there are several limitations of the present study. Some would argue that the fact that the researcher inherently is a part of the research process, could bias the results (Kvale, 1996). The data can be understood and interpreted in several than ways, depending on many things such as characteristics of the researcher as well as theoretical orientation. By having an interview-guide which in part were based on the specific components identified in the CBT literature, the account presented could be biased in favor of CBT. However, negative aspects of CBT were also portrayed. Moreover, to reduce the potential for researcher bias, one could ideally have several researchers interpreting the results (Kvale, 1996). However, due to time-limitations, this could not be done in the present study.

An important limitation is the fact that many of the informants did not attend all the sessions. Their recollection of how they experienced the course may therefore be biased, and some of the informants said that they remembered little about specific components. However, as most of the components are a part of more than one of the sessions, the importance of this bias may be limited.

Although it is usually not appropriate to generalize qualitative findings beyond the group studied, it is useful to consider if the group studied differ on important variables compared to

other depressed adolescents. Considering the relatively low rate of adolescents (33 %) who volunteered to take part in the interview study, it is possible that those who consented differ on important variables compared to the participants who declined participation in the interview study. When comparing the interview-group with the other participants at the four courses, there was a non-significant tendency that the interview-group had higher scores on BDI. Moreover, the pre-post change in BDI scores was very similar for those who volunteered to participate and those who declined, and both groups had a statistically significant reduction in reported symptoms of depression. In addition, there were no noteworthy differences between the groups in terms distribution of age, gender and type of education. Considering these variables, the informants do not seem to differ significantly from those who declined participation in the interview study, other than a slight tendency towards having more depressive symptoms.

There is a clear gender difference in the sample, including seven girls and two boys. However, a gender difference depression that emerges in adolescence (Hankin & Abramson, 2001; Wichstrøm, 1999), and by late adolescence girls are twice as likely as boys to be depressed (Nolen-Hoeksema, 2001). Considering this, the gender difference in this sample is not that different for in the adolescent population in general. Nevertheless, it could be that the results in the present study to a greater extent reflect how girls experience such interventions.

Many of the informants also reported having previous or present symptoms of anxiety, and this may affect how the informants experienced the intervention. However, there is a high rate of co-occurrence between depression and anxiety (see e.g., Costello et al., 2003). Consequently, this may not be a limitation of the present study, as this is common in the clinical picture of depression.

Another limitation could pertain to the fact that some of the interviews were conducted face-to-face, while the majority was conducted by telephone. However, a study by Sturges and Hanrahan (2004) compared the use of face-to-face interviews with interviews conducted by

telephone. They found no differences between these two modes of interviewing in terms of quantity, nature, and depth of responses. In general, the interviews conducted face-to-face were somewhat longer than the ones conduced by telephone. However, this could be due to many reasons, for instance characteristics of the informants. Furthermore, the interviews were conducted in Norwegian, and to be intelligible in English, some of the sentences were reorganized. Accordingly, some of the original meaning of the quotations could be lost in translation.

Another factor that could have affected the results of the present study is the instructors' treatment adherence, which can be defined as the degree to which the therapist utilizes prescribed procedures and avoids proscribed procedures (Perepletchikova, Treat, & Kazdin, 2007). Treatment adherence is viewed as an element of treatment integrity, referring to whether an intervention is implemented as planned. A limitation concerning the execution of the intervention in the present study, is the lack of measure of treatment adherence or treatment integrity. There were indications in the results that the behavioral activation component seemed to have a somewhat different focus at the different courses. At one of the courses, one of the informants mentioned that they were given an overview of different kinds of pleasurable activities. This was not a part of the course-manual, but a part of the similar adult intervention for depression. On this basis, one could question if the participants actually were exposed to the same course, which could affect the results of the present study. Poor treatment adherence could imply that it is somewhat difficult to compare the informants at the different courses experiences, as they may not have received exactly the same intervention. The fact that the treatment adherence was not optimal could also be due to the fact that this was the first time this course was conducted. In addition, the instructors may have personal opinions about what they thought should be included in the course. However, there do not seem to be large differences between the courses, as they in general seem to be alike. Even though there were no measures of

treatment integrity in this study, other actions were taken to better ensure that the instructors followed the manual. For instance, all the instructors had to go through a five-day training program, and many of the instructors had previous experience in conducting a similar group intervention for adults.

Conclusion and Implications for Further Research

In general, the informants experienced the CBT group intervention as beneficial. More specifically, all of them reported experiencing the psycho-educative part as useful. However, when considering the practical techniques such as identification of thoughts, and cognitive restructuring, they experienced these as valuable, but somewhat difficult to use. Nevertheless, it was uttered that the cognitive aspects of the course were the most useful. Through gaining knowledge about how their thinking affects emotions and behavior, the informants seemed to have become more aware of how to regulate their emotional reactions.

Behavioral activation was also considered as very beneficial by most of the informants, and was frequently used. However, due to relatively limited amount of time devoted to the behavioral activation component in the intervention in the present study, there was somewhat limited opportunity to study this component. The focus on social relationships was also somewhat limited, but this part of the course was in general perceived as valuable. Few of the informants reported the relaxation training as beneficial, but some of them already had relaxation-exercises in advance. The homework was perceived as somewhat difficult, and most of the informants did not always do the homework due to various reasons. Nevertheless, most of them thought that the homework-assignments were necessary for a beneficial intervention.

The fact that the informants in the present study found the cognitive aspects of the intervention as the most beneficial, but somewhat difficult to use, is important information. There is a need for more qualitative studies to explore how adolescents experience this and

other aspects of CBT interventions, as this may offer important insights. However, due to the apparent difficulties in generalizing from qualitative studies, quantitative studies, with larger sample size and a more rigorous method are also needed to determine if this applies to depressed adolescents in general. Dismantling studies is perhaps the best design to determine the effectiveness of the specific CBT components, but questionnaires could also be applied to explore adolescents' experiences in a larger scale.

As for possible negative aspects of CBT interventions, it is important to be aware of the possibility of experiencing guilt in relation to negative thinking and negative emotional experiences. Whether or not this is a common problem when conducting CBT interventions needs to be explored in further research, as well as strategies that can be applied to counter these detrimental effects. Perhaps acceptance-based procedures drawn from other traditions, such as mindfulness, could be included to balance the focus on change strategies.

Considering the group aspect, this was mainly regarded as positive. Meeting people in a similar situation contributed to normalization of the adolescents' depressive symptoms, and a possibility of making new friends. Moreover, the informants uttered a preference for the group format compared to individual approaches, as the latter one may be experienced as too intense. If adolescents experience the group format as less intense and thereby more attractive than individual approaches need to be examined in further research, as this might have important implications towards clinical practice. There is also a need for research addressing the influence of nonspecific factors, such as group processes, on the clinical outcome of CBT group interventions.

References

Abramson, L. Y., Metalsky, G. I., & Alloy, L. B. (1989). Hoplessness depression: A theory-based subtype of depression. *Psychological Review, 96*(2), 358-372.

Angst, J., Sellaro, R., & Merikangas, K. R. (2000). Depressive spectrum diagnoses. *Comprehensive Psychiatry, 41*(2), 39-47.

APA. (1994). *Diagnostic and statistical manual of mental disorders, fourth edition (DSM-IV)*. Washington, DC: American Psychiatric Association.

Barney, L. J., Griffiths, K. M., Jorm, A. F., & Christensen, H. (2006). Stigma about depression and its impact on help-seeking intentions. *Australian and New Zealand Journal of Psychiatry, 40*(1), 51-54.

Beck, A. T. (1970). *Depression: Causes and treatment* (1 ed.). Philadelphia: University of Pennsylvania Press.

Beck, A. T., Rush, J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: The Guilford Press.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561-571.

Bieling, P. J., McCabe, R. E., & Antony, M. M. (2006). *Cognitive-behavioral therapy in groups*. New York: The Guilford Press.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Brent, D. A., Holder, D., Kolko, D., Birmaher, B., Baugher, M., Roth, C. et al. (1997). A clinical psychotherapy trial for adolescent depression comparing cognitive, family, and supportive therapy. *Archives of General Psychiatry, 54*(9), 877-885.

Bright, J. I., Baker, K. D., & Neimeyer, R. A. (1999). Professional and paraprofessional group treatments for depression: A comparison of cognitive-behavioral and mutual

support interventions. *Journal of Consulting and Clinical Psychology, 67*(4), 491-501.

Burlingame, G. M. (2010). Small group treatments: Introduction to special section. *Psychotherapy Research, 20*(1), 1-7.

Burlingame, G. M., Fuhriman, A., & Johnson, J. E. (2002). Cohesion in group psychoytherapy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 71-87). New York: Oxford University Press.

Burlingame, G. M., MacKenzie, K. R., & Strauss, B. (2004). Small-group treatment: Evidence for effectiveness and mechanisms of change. In M. J. Lambert, A. E. Bergin & S. L. Garfield (Eds.), *Bergin and Lambert's handbook of psychotherapy and behavior change* (5 ed., pp. 647-696). New York: Wiley.

Bøgwald, K. P. (2001). Do patients and their therapists agree on the content of treatments? *The Journal of Nervous and Mental disease, 189*(12), 830-837.

Børve, T. (2010). Manual for depresjonsmestring for ungdom.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66*(1), 7-18. doi: 10.1037/0022-006x.66.1.7

Clarke, G. N., Debar, L., & Lewinsohn, P. M. (2003). Cognitive-behavioral group treatment for adolescent depression. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (1 ed., pp. 120-134). New York: The Guilford Press.

Compton, S. N., March, J. S., Brent, D., Albano, A. M., Weersing, V. R., & Curry, J. (2004). Cognitive-Behavioral Psychotherapy for Anxiety and Depressive Disorders in Children and Adolescents: An Evidence-Based Medicine Review. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*(8), 930-959.

Costello, E. J., Mustillo, S., Erkanli, A., Keeler, G., & Angold, A. (2003). Prevalence and Development of Psychiatric Disorders in Childhood and Adolescence. *Archives of General Psychiatry, 60*(8), 837-844. doi: 10.1001/archpsyc.60.8.837

Creswell, J. W. (2007). *Qualitative inquiry and research design - choosing among five approaches* (2 ed.). Thousand Oaks: Sage Publications.

Cuijpers, P., Muñoz, R. F., Clarke, G. N., & Lewinsohn, P. M. (2009). Psychoeducational treatment and prevention of depression: The "coping with depression" course thirty years later. *Clinical Psychology Review, 29*(5), 449-458. doi: 10.1016/j.cpr.2009.04.005

Dalgard, O. S. (2004). Kurs i mestring av depresjon - en randomisert, kontrollert studie. *Tidsskrift for den Norske Lægeforening, 124*(23), 3043-3046.

David-Ferdon, C., & Kaslow, N. J. (2008). Evidence-based psychosocial treatments for child and adolescent depression. *Journal of Clinical Child and Adolescent Psychology, 37*(1), 62-104. doi: 10.1080/15374410701817865

De Goede, I. H. A., Branje, S. J. T., & Meeus, W. H. J. (2009). Developmental changes in adolescents' perceptions of relationships with their parents. *Journal of Youth and Adolescence, 38*(1), 75-88.

Dimidjian, S., Hollon, S. D., Dobson, K. S., Schmaling, K. B., Kohlenberg, R. J., Addis, M. E. et al. (2006). Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the acute treatment of adults with major depression. *Journal of Consulting and Clinical Psychology, 74*(4), 658-670.

Dobson, K. S., Hollon, S. D., Dimidjian, S., Schmaling, K. B., Kohlenberg, R. J., Gallop, R. J. et al. (2008). Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the prevention of relapse and recurrence in major depression. *Journal of Consulting and Clinical Psychology, 76*(3), 468-477.

Elliott, R., & James, E. (1989). Varieties of client experience in psychotherapy: An analysis of the literature. *Clinical Psychology Review, 9*, 443-467.

Ellis, A., & Dryden, W. (1987). *The practice of rational-emotive therapy*. New York: Springer publishing company.

Engler, B. (2008). *Personality theories* (8 ed.). Boston: Houghton Mifflin Company.

Essau, C. A., & Chang, W. C. C. (2009). Epidemiology, comorbidity and course of adolescent depression. In C. A. Essau (Ed.), *Treatments for adolescent depression - theory and practice*. New York: Oxford University Press.

Fennell, M. J. V. (1989). Depression. In K. Hawton, P. M. Salkovskis, J. Kirk & D. M. Clark (Eds.), *Cognitive behavioral therapy for psychiatric problems* (pp. 169-234). New York: Oxford Medical Publications.

Finucane, A., & Mercer, S. W. (2006). An exploratory mixed methods study of the acceptability and effectiveness of mindfulness-based cognitive therapy for patients with active depression and anxiety in primary care. *BMC Psychiatry, 6*. doi: 10.1186/1471-244X-6-14

Furman, W., & Buhrmester, D. (1992). Age and Sex Differences in Perceptions of Networks of Personal Relationships. *Child Development, 63*, 103-115.

Garber, J., Weiss, B., & Shanley, N. (1993). Cognitions, depressive symptoms, and development in adolescents. *Journal of Abnormal Psychology, 102*(1), 47-57.

Garratt, G., Ingram, R. E., Rand, K. L., & Sawalani, G. (2007). Cognitive processes in cognitive therapy: Evaluation of the mechanisms of change in the treatment of depression. *Clinical Psychology-Science and Practice, 14*(3), 224-239.

Gaynor, S. T., Lawrence, P. S., & Nelson-Gray, R. O. (2006). Measuring Homework Compliance in Cognitive-Behavioral Therapy for Adolescent Depression: Review,

Preliminary Findings, and Implications for Theory and Practice. *Behavior Modification, 30*(5), 647-672.

Halvorsen, P. (2009). Gjennomslag for lavterskeltilbud i regjeringserklæringen. Retrieved 03.12, 2009, from http://www.psykologforeningen.no/pf/Foreningen/Politikk/Hovedsatsingsomraade-2008-2010/Gjennomslag-for-lavterskeltilbud-i-regjeringserklaeringen

Hankin, B. L., & Abramson, L. Y. (2001). Development of gender differences in depression: An elaborated cognitive vulnerability–transactional stress theory. *Psychological Bulletin, 127*(6), 773-796. doi: 10.1037/0033-2909.127.6.773

Hayden, E. P., Seeds, P. M., & Dozois, D. J. A. (2009). Risk and vulnerability in adolescent depression. In C. Essau (Ed.), *Treatments for adolescent depression* (pp. 27-56). New York: Oxford University Press.

Helland, M. J., & Mathiesen, K. S. (2009). 13-15-åringer fra vanlige familier i Norge - hverdagsliv og psykisk helse. Oslo: Nasjonalt folkehelseinstitutt.

Hodgetts, A., & Wright, J. (2007). Researching clients' experiences: A review of qualitative studies. *Clinical Psychology & Psychotherapy, 14*(3), 157-163.

Hofgaard, T. L. (2008). Hvorfor psykologisk lavterskeltilbud? Retrieved 03.12, 2009, from http://www.psykologforeningen.no/pf/Foreningen/Politikk/Hovedsatsingsomraade-2008-2010/Hvorfor-psykologisk-lavterskeltilbud,

Holmbeck, G., Greenley, R. N., & Franks, E. A. (2003). Developmental issues and considerations in research and practice. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (1 ed., pp. 21-41). New York: The guilford press.

Hornsey, M. J., Dwyer, L., & Oei, T. P. S. (2007). Beyond cohesiveness: Reconceptualizing the link between group processes and outcomes in group psychotherapy. *Small Group Research, 38*, 567-592.

Hougaard, E. (2004). *Psykoterapi. Teori og forskning* (2 ed.). København: Dansk psykologisk forlag.

Jacobson, N. S., Dobson, K. S., Truax, P. A., Addis, M. E., Koerner, K., Gollan, J. K. et al. (2000). A component analysis of cognitive–behavioral treatment for depression. *Prevention & Treatment, 3*(1). doi: 10.1037/1522-3736.3.1.323a

Jorm, A. F., Morgan, A. J., & Hetrick, S. E. (2009). Relaxation for depression. *Cochrane Database of Systematic Reviews*(4). doi: Cd00714210.1002/14651858.CD007142.pub2

Kazantzis, N., & Lampropoulos, G. K. (2002). Reflecting on homework in psychotherapy: What can we conclude from research and experience? *Journal of Clinical Psychology, 58*(5), 577–585.

Kennard, B. D., Clarke, G. N., Weersing, V. R., Asarnow, J. R., Shamseddeen, W., Porta, G. et al. (2009). Effective components of TORDIA cognitive–behavioral therapy for adolescent depression: Preliminary findings. *Journal of Consulting and Clinical Psychology, 77*(6), 1033-1041.

Kessler, R. C., Avenevoli, S., & Merikangas, K. R. (2001). Mood disorders in children and adolescents: An epidemiologic perspective. *Biological Psychiatry, 49*(12), 1002-1014. doi: 10.1016/s0006-3223(01)01129-5

Kessler, R. C., & Walters, E. E. (1998). Epidemiology of DSM-III-R major depression and minor depression among adolescents and young adults in the national comorbidity survey. *Depression and Anxiety, 7*(1), 3-14.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. Thousand Oaks: Sage Publications, Inc.

Lakdawalla, Z., Hankin, B. L., & Mermelstein, R. (2007). Cognitive theories of depression in children and adolescents: A conceptual and quantitative review. *Clinical Child and Family Psychology Review, 10*(1), 1-24. doi: 10.1007/s10567-006-0013-1

Lewinsohn, P. M., & Clarke, G. N. (1999). Psychosocial treatments for adolescent depression. *Clinical Psychology Review, 19*(3), 329-342. doi: 10.1016/S0272-7358(98)00055-5

Lewinsohn, P. M., Rohde, P., & Seeley, J. R. (1998). Major depressive disorder in older adolescents: Prevalence, risk factors, and clinical implications. *Clinical Psychology Review, 18*(7), 765-794. doi: 10.1016/S0272-7358(98)00010-5

Lockwood, C., Page, T., & Conroy-Hiller, T. (2004). Comparing the effectiveness of cognitive behaviour therapy using individual or group therapy in the treatment of depression. *International Journal of Evidence-Based Healthcare, 2*(5), 185-206.

Macran, S., Ross, H., Hardy, G. E., & Shapiro, D. A. (1999). The importance of considering clients' perspectives in psychotherapy research. *Journal of Mental Health, 8*(4), 325-337.

March, J. S., & Vitiello, B. (2009). Clinical messages from the Treatment for Adolescents with Depression Study (TADS). *The American Journal of Psychiatry, 166*(10), 1118-1123. doi: 10.1176/appi.ajp.2009.08101606

Mathers, C. D., & Loncar, D. (2006). Projections of Global Mortality and Burden of Disease from 2002 to 2030. *PLoS Med, 3*(11), e442.

Mathiesen, K. S. (2009). Psykisk lidelser i Norge: Et folkehelseperspektiv. Del 2: Barn og unge. Oslo: Nasjonalt folkehelseinstitutt.

Mausbach, B. T., Moore, R., Roesch, S., Cardenas, V., & Patterson, T. L. (2010). The relationship between homework compliance and therapy outcomes: An updated meta-analysis. *Cognitive Therapy and Research, 34*, 429-438.

McCarty, C. A. P. D., & Weisz, J. R. P. D. (2007). Effects of Psychotherapy for Depression in Children and Adolescents: What We Can (and Can't) Learn from Meta-Analysis and Component Profiling. *Journal of the American Academy of Child & Adolescent Psychiatry July, 46*(7), 879-886.

Messari, S., & Hallam, R. (2003). CBT for psychosis: A qualitative analysis of clients' experiences. *British Journal of Clinical Psychology, 42*, 171-188.

Michael, K. D., & Crowley, S. L. (2002). How effective are treatments for child and adolescent depression?: A meta-analytic review. *Clinical Psychology Review, 22*(2), 247-269. doi: 10.1016/S0272-7358(01)00089-7

Montgomery, E. C., Kunik, M. E., Wilson, N., Stanley, M. A., & Weiss, B. (2010). Can paraprofessionals deliver cognitive-behavioral therapy to treat anxiety and depressive symptoms? *Bulletin of the Menninger Clinic, 74*(1), 45-62.

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications.

Mykletun, A., Knudsen, A. K., & Mathiesen, K. S. (2009). Psykiske lidelser i Norge: Et folkehelseperspektiv. Oslo: Nasjonalt folkehelseinstitutt.

Newton, E., Larkin, M., Melhuish, R., & Wykes, T. (2007). More than just a place to talk: Young people's experiences of group psychological therapy as an early intervention for auditory hallucinations. *Psychology and Psychotherapy: Theory, Research and Practice, 80*(1), 127-149. doi: 10.1348/147608306x110148

Nolen-Hoeksema, S. (2001). Gender differences in depression. *Current Directions in Psychological Science, 10*(5), 173-176.

Oei, T. P. S., & Shuttlewood, G. J. (1996). Specific and nonspecific factors in psychotherapy: A case of cognitive therapy for depression. *Clinical Psychology Review, 16*(2), 83-103.

Paradis, A. D., Reinherz, H. Z., Giaconia, R. M., & Fitzmaurice, G. (2006). Major depression in the transition to adulthood: The impact of active and past depression on young adult functioning. *The Journal of Nervous and Mental disease, 194*(5), 318-323.

Perepletchikova, F., Treat, T. A., & Kazdin, A. E. (2007). Treatment integrity in psychotherapy research: Analysis of the studies and examination of the associated factors. *Journal of Consulting and Clinical Psychology, 75*(6).

Psykologforeningen. (2008). Definisjon av lavterskeltjenester. Retrieved 03.12, 2009, from http://www.psykologforeningen.no/pf/Foreningen/Politikk/Hovedsatsingsomraade-2008-2010

QSR. (2008). Nvivo 8. Doncaster, Victoria: QSR International.

Rao, U., Hammen, C., & Daley, S. E. (1999). Continuity of depression during the transition to adulthood: A 5-year longitudinal study of young women. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*(7), 908-915.

Reinecke, M. A., Ryan, N. E., & DuBois, D. L. (1998). Cognitive-behavioral therapy of depression and depressive symptoms during adolescence: A review and meta-analysis. *Journal of the American Academy of Child & Adolescent Psychiatry, 37*(1), 26-34.

Rosselló, J., Bernal, G., & Rivera-Medina, C. (2008). Individual and group CBT and IPT for Puerto Rican adolescents with depressive symptoms. *Cultural Diversity and Ethnic Minority Psychology, 14*(3), 234-245. doi: 10.1037/1099-9809.14.3.234

Scher, C. D., Ingram, R. E., & Segal, Z. V. (2005). Cognitive reactivity and vulnerability: Empirical evaluation of construct activation and cognitive diatheses in unipolar depression. *Clinical Psychology Review, 25*(4), 487-510. doi: 10.1016/j.cpr.2005.01.005

Segal, Z. V., Teasdale, J. D., & Williams, M. G. (2004). Mindfulness-based cognitive therapy: Theoretical rationale and empirical status. In S. C. Hayes, V. M. Follette & M. M. Linehan (Eds.), *Mindfulness and acceptance: Expanding the cognitive-behavioral tradition* (pp. 45-65). New York.

Shirk, S. R., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 71*(3), 452-464. doi: 10.1037/0022-006x.71.3.452

Stark, K. D., Sander, J., Hauser, M., Simpson, J., Schnoebelen, S., Glenn, R. et al. (2006). Depressive disorders during childhood and adolescence. In E. J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorders* (3 ed.). New York: The Guildford Press.

Sturges, J. E., & Hanrahan, K. J. (2004). Comparing telephone and face-to-face qualitative interviewing: a research note. *Qualitative Research, 4*(107), 107-118. doi: 10.1177/1468794104041110

Tucker, M., & Oei, T. P. S. (2007). Is Group More Cost Effective than Individual Cognitive Behaviour Therapy? The Evidence is not Solid Yet. *Behavioural and Cognitive Psychotherapy, 35*(01), 77-91. doi: 10.1017/S1352465806003134

Weersing, V. R., Rozenman, M., & Gonzalez, A. (2009). Core components of therapy in youth: Do we know what to disseminate? *Behavior Modification, 33*(1), 24-47. doi: 10.1177/0145445508322629

Weissman, M. M., Wolk, S., Goldstein, R. B., Moreau, D., Adams, P., Greenwald, S. et al. (1999). Depressed adolescents grown up. *JAMA: Journal of the American Medical Association, 281*(18), 1707-1713. doi: 10.1001/jama.281.18.1707

Weisz, J. R., & Hawley, K. M. (2002). Developmental factors in the treatment on adolescents. *Journal of Consulting and Clinical Psychology, 70*(1), 21-43. doi: 10.1037/0022-006x.70.1.21

Weisz, J. R., McCarty, C. A., & Valeri, S. M. (2006). Effects of psychotherapy for depression in children and adolescents: A meta-analysis. *Psychological Bulletin, 132*(1), 132-149. doi: 10.1037/0033-2909.132.1.132

Wells, A. (2008). Metacognitive therapy: Cognition applied to regulating cognition. *Behavioural and Cognitive Psychotherapy, 36*, 651-658. doi: 10.1017/S1352465808004803

Whitaker, A., Johnson, J., Shaffer, D., & Rapoport, J. L. (1990). Uncommon troubles in young people: Prevalence estimates of selected psychiatric disorders in a nonreferred adolescent population. *Archives of General Psychiatry, 47*(5), 487-496.

White, J. R. (2000). Depression. In J. R. White & A. S. Freeman (Eds.), *Cognitive-behavioral group therapy: For specific problems and populations* (pp. 29-61). Washington, DC: American Psychological Association.

Wichstrøm, L. (1999). The emergence of gender difference in depressed mood during adolescence: The role of intensified gender socialization. *Developmental Psychology, 35*(1), 232-245. doi: 10.1037/0012-1649.35.1.232

Yalom, I. (1995). *The theory and practice of group psychotherapy* (4 ed.). New York: Basic Books.

Appendix A

Diagnostic Criteria Major Depressive Disorder in DSM-IV

A.	Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. **Note:** Do not include symptoms that are clearly due to a general medical condition or mood-incongruent delusions or hallucinations. **(1)** depressed mood most of the day, nearly every day. In children and adolescents, this can be irritable mood. **(2)** markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day. **(3)** significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. In children, consider failure to make expected weight gains. **(4)** insomnia or hypersomnia nearly every day **(5)** psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down) **(6)** fatigue or loss of energy nearly every day **(7)** feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day **(8)** diminished ability to think or concentrate, or indecisiveness, nearly every day **(9)** recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
B.	The symptoms do not meet criteria for a Mixed Episode.
C.	The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D.	The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
E.	The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Appendix B

Interview-guide

Informasjon om intervjuet til deltakere (før lydopptaket starter)

a) Hensikten med undersøkelsen / nytteverdi
   - Skal spørre om hvordan dere opplever nytteverdien av ulike komponenter i kurset.

b) Informasjonen som gis behandles strengt konfidensielt, skal ikke være mulig å identifisere dere i den ferdige oppgaven.

c) Informasjon om taushetsplikten og unntak ved denne (for eksempel hvis det er fare for å skade seg selv eller andre)

d) Tidsbruk – en til halvannen time

e) Frivillighet og anledning til å trekke seg

f) Mulighet for pause

g) Noen spørsmål?

Bakgrunnsinformasjon

a) Alder

b) Kjønn

c) Utdanning/yrke

Bakgrunn for påmelding på "Depresjonsmestring for ungdom"

d) Hva var grunnen til at du meldte deg på kurset? / Hva var grunnen til at du tenkte at dette tilbudet kunne passe for deg?

e) Hvor, og eventuelt fra hvem, fikk du informasjon om kurset?

f) Hvilken informasjon ga de om kurset på forhånd/hvordan annonserte de kurset?

g) Hvilke forventninger hadde du til kurset på forhånd?

h) Hvordan var motivasjonen for kurset på forhånd?

i) Hva tenkte du om depresjonen din på forhånd? / Hva trodde var årsaken til depresjonen?

PSYKOEDUKASJON

1. *Gjennom kurset skal dere ha blitt informert om ulike kjennetegn ved depresjon. Har dere fått informasjon om dette?*

Hva synes du om denne delen av kurset?

1. Var det noe som var vanskelig å forstå?
2. Hvordan var det å bli informert/få kunnskap om dette?
3. Hvordan opplever du nytteverdien av denne delen av kurset? / Var det nyttig å få informasjon om dette?

2. *Gjennom kurset skal dere også ha blitt undervist om sammenhengen mellom tanker og følelser, spesielt hvordan tanker kan føre til nedstemthet og følelse av mangel på energi. Har dere vært igjennom dette?*

Hva synes du om denne delen av kurset?

1. Var det noe som var vanskelig å forstå?
2. Hvordan var det å bli informert/få kunnskap om dette?
3. Hvordan opplever du nytteverdien av denne delen av kurset? / Var det nyttig å få informasjon om dette?

SELVMONITORERING AV TANKER og FØLELSER

Et annet hovedtema i kurset dreier seg om å gjenkjenne tanker som kan føre til nedstemthet og følelse av mangel på energi, og hvilke situasjoner disse tankene kan oppstå i. Har dere vært igjennom dette?

Hva synes du om denne delen av kurset?

1. Var det noe som var vanskelige å forstå i denne delen av kurset?
2. Hvordan var det å gjenkjenne/få fatt i negative automatiske tanker/den indre dialogen?
3. Hvordan var det å få kartlagt i hvilke situasjoner disse tankene forekommer?
4. I hvilken grad har du gjort bruk av kunnskapen og ferdighetene som ble formidlet/legger du fremdeles merke til hva du tenker/sier til deg selv i ulike situasjoner?
5. Hvordan opplever du nytteverdien av denne delen av kurset / På hvilken måte opplever du å ha hatt nytte av denne delen av kurset?

RESTRUKTURERING AV TANKER

Et annet tema fokuserer på endring av tankemønstre som kan føre til nedstemthet og følelse av mangel på energi. Har dere vært igjennom dette?

Hva synes du om denne delen av kurset?

1. Var det noe som var vanskelige å forstå i denne delen?
2. Hvordan var det å tilegne seg ferdighetene som ble formidlet/endre tanker/finne alternative tanker/positive tanker?
3. Bruker du positive tanker/alternative tanker i dag for å bryte negative tankemønstre?
4. Hvordan opplever du nytteverdien av denne delen av kurset / På hvilken måte opplever du å ha hatt nytte av denne delen av kurset? Synes du det er nyttig å finne alternative tolkninger/tenke positivt?

AVSLAPNINGSTEKNIKKER

1. Progressiv muskelavspenning

Et annet tema i kurset dreier seg om muskelavspenning. Har dere vært igjennom dette?

Hva synes du om denne delen av kurset?

1. Var det noe som var vanskelig å forstå?
2. Hvordan var det å tilegne seg/lære seg avslapningsteknikkene? Vanskelig?
3. I hvilken grad har du gjort bruk av avslapningsteknikkene?

4. Hvordan opplever du nytteverdien av denne delen av kurset / På hvilken måte opplever du å ha hatt nytte av denne delen av kurset?
5. Når/Hvilke situasjoner har denne teknikken vært nyttig i?

2. Visualisering av en god opplevelse/visualisering av trygt sted

En annen avslapningsteknikk dreier seg om å forestille seg en gang hvor du hadde det veldig bra. Har dere vært igjennom dette?

Hva synes du om denne delen av kurset?

1. Var det noe som var vanskelig å forstå?
2. Hvordan var det å tilegne seg/lære seg visualisering av trygt sted? Vanskelig?
3. I hvilken grad har du gjort bruk av visualisering av trygt sted?
4. Hvordan opplever du nytteverdien av denne delen av kurset / På hvilken måte opplever du å ha hatt nytte av denne delen av kurset?
5. Når/Hvilke situasjoner har denne teknikken vært nyttig i?

POSITIVE AKTIVITETER

Et tema dreide seg om å søke situasjoner eller aktiviteter som gir gode følelser for å redusere tristhet og mangel på energi. Har dere vært igjennom dette?

Hva synes du om denne delen av kurset:

1. Var det noe som var vanskelig å forstå?
2. I hvilken grad har du gjort bruk av denne kunnskapen / har du gjort/tenkt på noe som gir gode følelser oftere etter at du begynte på kurset?
3. Har du fått ideer til aktiviteter/situasjoner som kan gi deg positive opplevelser/gode følelser? / Kan du i tilfellet gi eksempler?
4. Hvordan opplever du nytteverdien av denne delen av kurset / På hvilken måte opplever du å ha hatt nytte av denne delen av kurset?

SOSIALE RELASJONER

Et annet tema dreide seg om det å ta vare på eller etablere nye støttende sosiale kontakter. Har dere vært igjennom dette?

Hva synes du om denne delen av kurset:

1. Var det noe som var vanskelig å forstå?
2. I hvilken grad synes du kurset har gitt deg hjelp til å ta vare på eller etablere nye støttende sosiale relasjoner? På hvilken måte?
3. Har dine sosiale kontakter endret seg etter kurset? Er du mer/mindre sammen med andre?
4. Har dette påvirket ditt psykiske velvære?
5. Hvordan opplever du nytteverdien av denne delen av kurset? / På hvilken måte opplever du å ha nytte av denne delen av kurset?

HJEMMEOPPGAVER

Gjennom kurset skal dere ha fått ulike hjemmeoppgaver, stemmer dette?

Hva synes du om denne delen av kurset?

1. Var det noe i hjemmeoppgavene som var vanskelig å forstå?
2. Var det vanskelig å gjennomføre hjemmeoppgavene? Gjorde du hjemmeoppgavene hver gang?
3. Hvordan opplever du nytteverdien av denne delen av kurset? På hvilken måte var det nyttig?

GRUPPEFORMATET

Kurset gjennomføres for grupper av ungdommer.

1. Hvordan synes du det var å møte andre ungdommer i liknende situasjon?
2. Hva synes du har vært fordelen med å være i grupper?
3. Er det noe du synes har vært vanskelig med dette (for eksempel er det ting du ikke har kunnet ta opp eller få hjelp til).
4. Tror du at du kommer til å ha kontakt med noen av de andre gruppemedlemmene etterpå?
5. Dersom du skulle velge om igjen, og hadde valget mellom å gå til psykolog alene (individualterapi) eller å gå i en slik gruppe, hva ville du ha valgt da?

FORELDRE og LÆRERINFORMASJON

"Depresjonsmestring for ungdom" inneholder også et hefte til foreldrene med informasjon om depresjon, samt kursets innhold. Har foreldrene dine mottatt dette? Jeg vil derfor stille spørsmål om det har vært en endring i relasjonen til foreldrene i løpet av kursperioden.

1. Vet du om foreldre eller foresatte har lest denne informasjonen?
2. I tilfellet ja, oppfatter du at de synes informasjonen var nyttig? Har de sagt noe om hvordan de synes det var nyttig?
3. Har du opplevd endringer i relasjonen til foreldrene dine i løpet av kursperioden?
4. Har dette hatt betydning for ditt psykiske velvære og i tilfellet hvordan?

OPPSUMMERING

1. Svarte kurset til forventingene du hadde på forhånd?
    a. På hvilken måte?
2. Har det endret måten du tenker rundt egen depresjon på? Har det endret måten du tenker på om årsaken til egen depresjon?
3. Har kurset endret måten du tenker på rundt mulig depresjon i fremtiden? / Tror du at det er mindre sannsynlig at du blir deprimert i fremtiden?
4. Hvordan har motivasjonen for deltakelse på kurset vært underveis?
5. Hvordan har motivasjonen for hjemmeoppgavene vært?
6. Synes du tidsbruken har vært passelig?
    a. Antall kursdager – deltatt på alle?
    b. Varighet på kursdagene?

   c. Hjemmeoppgaver
7. Alt i alt; Hva synes du var det mest nyttige ved kurset? / Hva var det beste med kurset?
8. Hvilke metoder/teknikker benytter du deg mest av? Hva bruker du minst?
   a. Hva er grunnen til at du bruker disse teknikkene mest/minst?
9. Hvis kurset har ført til endringer for din del, hvilke endringer har vært de mest betydningsfulle?
10. Er det noe du synes ikke burde ha vært med i kurset? Hva var det dårligste med kurset?
11. Er det noe du synes burde vært annerledes?
12. Vil du anbefale andre å delta på kurset? Har du anbefalt andre?
13. Er det andre ting ved kurset eller din opplevelse av kurset som du ønsker å kommentere?

Bakgrunnsspørsmål om depresjon og andre psykiske lidelser

a. Hvordan hadde du det/var du deprimert da du meldte deg på kurset/før kurset startet?
   i. *Depressive symptomer*: Nedstemthet, interesse- og gledesløshet, energitap, redusert konsentrasjon og oppmerksomhet, redusert selvfølelse og selvtillit, skyldfølelse og mindreverdighetsfølelse, triste og pessimistiske tanker om fremtiden, selvmordstanker, søvnproblemer, redusert appetitt.
   ii. Hvor lenge hadde du vært deprimert da?
   iii. Var du i kontakt med behandlingsapparat i forbindelse med depresjon i forkant av kurset?
      1. I tilfelle ja, hvilken form for behandling?
         a. Medikamentell behandling
         b. Samtaleterapi med psykolog eller annet helsepersonell
         c. Andre tiltak?
      2. Hvordan opplevde du utbytte av denne behandlingen?
b. Har du vært deprimert tidligere?
   i. Når?
   ii. Eventuelt hvor mange ganger?
   iii. Eventuelt hvor lenge av gangen?
   iv. Var du i kontakt med behandlingsapparatet da?
      1. I tilfelle ja, hvilken form for behandling?
         a. Medikamentell behandling
         b. Samtaleterapi med psykolog eller annet helsepersonell
         c. Andre tiltak?
      2. Hvordan opplevde du utbytte av denne behandlingen?
c. Var du deprimert da kurset begynte?
   i. Var du i kontakt med behandlingsapparat i forbindelse med depresjon under kurset?
      1. I tilfelle ja, hvilken form for behandling?
         a. Medikamentell behandling
         b. Samtaleterapi med psykolog eller annet helsepersonell
         c. Andre tiltak?
      2. Hvordan opplevde du utbytte av denne behandlingen?

d. Vil du si at du er deprimert nå?
    i. I tilfelle ja, er du mindre deprimert nå sammenliknet med før kurset begynte?
    ii. Eventuelt hvor lenge har du vært deprimert?
    iii. Sammenhengende, periodevis?
    iv. Mottar du noen form for behandling nå/ i etterkant av kurset?
        1. I tilfelle ja, hvilken form for behandling?
            a. Medikamentell behandling
            b. Samtaleterapi med psykolog eller annet helsepersonell
            c. Andre tiltak?
        2. Hvordan opplever du utbytte av denne behandlingen?
e. Har du eller har du hatt andre psykiske plager?
    i. Hvilke?
    ii. I tilfelle ja, mottar eller har du mottatt behandling for dette?
        1. Hvilken type behandling?
            a. Medikamentell behandling
            b. Samtaleterapi med psykolog eller annet helsepersonell
            c. Andre tiltak?
        2. Hvordan har du opplevd utbytte av denne behandlingen?

j) Er de depressive symptomene relatert til spesielle hendelser? Noe som du mener har utløst de depressive plagene?

k) Har andre i familien psykiske lidelser/andre i familien liknende vansker?